SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS SOCCA

INTERCHANGE

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PRESIDENT'S MESSAGE

A Holiday Season Like No Other

Miguel Cobas, MD, FCCM
President, SOCCA
University of Miami
Miami, FL

The holiday spirit is here! There are ornaments and festive music everywhere, Thanksgiving is still fresh in our memories, and the winter chill heralds the arrival of major religious holidays as well as the New Year. Yet, this year obviously feels different. For almost 12 months we have endured a pandemic that has transformed every aspect of our lives and will leave profound marks in the way we conduct ourselves for the foreseeable future.

The pandemic – if any silver lining can be ascribed – has highlighted the role of the anesthesiologist/intensivist like no other event in our lifetime. With intensive care units filled to capacity, the need for expert critical care, and requirements for exceptional airway management, we have positioned ourselves in the forefront of the crisis. In so doing we have showcased the relevance of our everyday work to the rest of our colleagues and the general public.

Over the summer SOCCA started a series of live monthly webinars that combined some of our Annual Meeting lectures with new timely and relevant material. These webinars, which provide CME credit, have been very well attended, and we have provided them at no cost to all participants during their original broadcasts. These webinars will be archived for later on-demand access by SOCCA members.

The Board Review Course, given over two days in the month of September, was also very well received and allowed our fellows to review topics that were particularly challenging in the most recent certification examination. This course, just like the webinars, is available on-demand to all SOCCA members, making membership in our Society an outstanding value even when only considering educational offerings.

The worth of belonging to SOCCA goes far beyond listening to extraordinary lectures by world-class faculty. The engagement of our members is critical for the growth of the specialty, and to that effect we have several initiatives to foster engagement, networking, and participation at all levels

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of training and career stage. Many of you have surely enjoyed lively interaction in the DocMatter® forums a virtual community dedicated to the sharing and discussion of critical care and COVID-19 topics among our professional community. We have received a very enthusiastic response from our younger members to the Anesthesia Toolbox® project, which is reviewed in the Education Committee update in this edition of Interchange. If you or your fellows would like to collaborate in the creation of content, please do get in touch with Dr. Jason Brainard (jason.brainard@ucdenver.edu).

Our Society's aspirations should be multidimensional and multiplatform: we want to be active and present in social media, as well as more conventional channels, like this newsletter and by email. To that effect, we have launched our newest offering, the SOCCA Drip, an aggregator of news, ideas, articles, and collaborations from our entire membership to be disseminated far and wide. The Drip aims to be varied in scope and latitude, and we would like to highlight a significant article as much as an important occurrence in your Department. You can send your ideas to SOCCA Society Director Vivian Abalama, IOM, CAE (vabalama@iars.org).

Looking ahead, please mark your calendars for our next Annual Meeting, which will take place virtually on May 14th, 2021; our educational committee is putting together an outstanding program. Do not forget to send in your abstract before January 15th.

I am very happy to report that our membership numbers have not only remained steady but are trending upward. Yes, we have been able to maintain relevance despite the current economic and difficult climate; this is a testament to the loyalty (may I say devotion?) of our members. All these offerings and products, however, are expensive, and as a small society we have a fiduciary responsibility to our members to assure that we invest our resources in the most responsible way.

Financially, a large portion of our expenses have shifted from hosting a location-based meeting to the electronic realm with associated costs for the production of high quality, virtual offerings that meet the standards you have always expected. Our income depends nearly exclusively on our annual dues. We are committed to providing exceptional value for your membership and to keep the prices of future courses and meetings as low as we can. Now, more than ever, SOCCA depends on you, our fellow intensivist, to maintain our growth and strengthen our future. I recognize there are many competing interests for an ever-shrinking pool of resources, yet I can confidently tell you that from fellowship to retirement, no society offers better value than SOCCA.

Wishing you the Best Holidays and a Happy New Year,

Miguel Cobas, MD, FCCM
President, SOCCA

SOCCA drip

We are excited to announce the launch of SOCCA Drip: a new online platform that 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

EDUCATION COMMITTEE UPDATE

"Zooming" Along To 2021

What a year! In continuing to improve well-organized bookcases and other real or virtual backdrops, we have clearly embraced the new normal. While the disappointment of missing real human contact associated with education is difficult to quantitate, there is certainly a silver lining to be appreciated. Developing and delivering didactic materials during a pandemic has required us to dig deep into the reserves of our creativity, and the results have been excellent to say the least. Look at the ease of access, wide outreach, and availability of speakers from all over the world, to name just a few benefits. Today we can proudly say that the SOCCA Education Committee, in conjunction with the membership of this incredible group, has established just the same.

Peter von Homeyer, MD, FASE
SOCCA Education Committee Chair
University of Washington
Seattle, WA

Once the 2020 Annual Meeting was canceled and its 2021 successor was designated as fully virtual, there was a lot of thinking to do. We had to go back to the drawing board quickly and rechart a course that would guide us towards remotely delivering the same high-quality content found at an in-person meeting. On behalf of the committee, we are thrilled to announce that the 2021 Annual Meeting schedule has been finalized. The date is set for the 14th of May, 2021, and the preliminary program is available here.

We received an unprecedentedly high number of panel proposals for the 2021 meeting. For this, the Education Committee thanks all of you, who, despite being the busiest you have ever been, came out and provided us the opportunity to look at so many diverse and unique proposals. We promise you that the 2021 Annual Meeting will be worth every minute of your time. Having said that, the committee has also made a constant effort to organize education with a focus on year-round activities. The monthly SOCCA webinar series is one such initiative. These webinars are off to a flying start, and we will continue to further develop them. The plans, as they currently stand, call for about 10 more webinars in 2021, some of which will feature proposals originally made for the Annual Meeting. We are also continually reviewing webinar content and taking in all the feedback that has been sent our way. Additionally, other educational endeavors are in the pipeline and nearly ready to roll out. These include select journal article reviews by experts within the committee and a series of video lecture series that will be featured on the SOCCA website as enduring content. On that note, our CME reviewers have worked incredibly hard, and continue to do so, to offer CME content for these and other new efforts. Please stay tuned and watch @SOCCA_CritCare and the SOCCA Drip for more news.

Ashish K. Khanna, MD, FCCP, FCCM
2021 Annual Meeting Chair and SOCCA Education Committee Vice-Chair
Wake Forest
Winston-Salem, NC

Work continues on the "Standardized National Critical Care Curriculum for Anesthesiology Residents." This project, a collaboration between SOCCA and Anesthesia Education Toolbox (AET), will develop a curriculum to be disseminated and available to all residency programs. Curriculum development will follow Kern's method, including an initial needs assessment and content mapping completed through an online Delphi process. The 1st round of the Delphi process is complete (with thanks to all who contributed), and after completion of the 3rd round, we will begin developing the curriculum outline. We will be looking for intensivists from across the country to help develop this curriculum and maintain its relevance.

Jason Brainard, MD
University of Colorado
Denver, CO

As background, AET is an educational platform with a mission "to collaboratively develop high quality peer-reviewed educational resources that can be shared by anesthesia training programs at the lowest possible cost." They currently have 63 academic training programs participating. The critical care curriculum is currently the least developed of all the subspecialty content, and this partnership will be mutually beneficial to both groups. AET benefits from SOCCA's reputation, expertise, and access to educators. SOCCA benefits from publicity and promotion through AET, the educational platform, and AET's expertise and experience in curriculum development. If you have any further questions about the project, please email Jason Brainard (jason.brainard@ucdenver.edu).

Humankind has learned a lot from COVID-19. One of the biggest lessons learned is that all of us – no matter where we work, what we do, and how much we work – have been affected by this virus. Whether at the personal or professional level, the scars are not yet even beginning to heal. The emotional toll of witnessing these ongoing difficulties daily have led to the biggest scars. If ever, now is the time to stand with each other. An encouraging phone call, or a message to say 'hi,' all count now in ways never felt before. Think about each other, and take the time reach out. And thank you for helping us build an ever-stronger SOCCA education mission. Stay safe.

COMMUNICATIONS COMMITTEE UPDATE

Craig S. Jabaley, MD
Chair, SOCCA Communications Committee
Emory University
Atlanta, GA

On behalf of the Communications Committee, we invite you to take a look at the newly launched SOCCA Drip online. To provide a greater wealth of resources to members in a timelier fashion, SOCCA Drip will be regularly updated to feature both long-form content written by members and brief topical highlights from the popular media, peer-reviewed literature, relevant professional societies, and other sources that will be of interest to the membership. We will continue to aggregate the majority of these features into our quarterly Interchange newsletter. The Committee's goals to amplify the accomplishments of SOCCA's members, disseminate relevant updates from the organization, and provide an outlet for information relevant to the membership have taken on renewed importance over the past year. To that end, member submissions are of the utmost importance to ensure that Drip (and therefore *Interchange*) remain relevant and valuable. As a committee, we would be happy either to take your ideas from concept to completion or to publish your original work—or anything in between. Please do reach out to SOCCA Society Director Vivian Abalama, IOM, CAE (vabalama@iars.org) so that we can help publish your ideas, thoughts, or achievements.

The Committee would also like to mention two additional resources. First, our Twitter account (@SOCCA_CritCare) remains fully at your disposal as a SOCCA member. In addition to spotlighting developments within SOCCA and new Drip updates, we would again like to amplify what you, your trainees, your peers, or your organizations are doing. We recently conducted a second Twitter journal club in conjunction with Anesthesia & Analgesia (@IARS_Journals) and would love to facilitate these types of collaborations with anyone who might be interested. Secondly, in March, SOCCA joined IARS in launching a physician-oriented online discussion forum via DocMatter. In a time where in-person networking has been externally constrained, the ability to discuss both clinical and non-clinical topics in a close online platform is of particular value.

In my capacity as editor of Interchange, I am thrilled that this issue features a diverse selection of pieces, which reflects our simultaneous confrontation of a pandemic respiratory virus (with clinical, professional, and personal impacts) alongside the other challenges with which we have historically contended. I would like to extend my thanks to everyone who took the time to put pen to paper (or fingers to keyboard) to express their viewpoints on the myriad ways that the last year has impacted, and will continue to impact, our subspecialty. As something of a hybrid between a scholarly and trade publication, *Interchange* will serve in the future to document how we felt, were affected by, and responded to this unique epoch. To that end, please do consider how SOCCA can help to broadcast and enduringly preserve your thoughts as a member of the community at a time that has served to spotlight the unique aspects and value of our subspeciality.

JOB BOARD

Read members-only job posts—including a role with Oregon Health & Science University, which is seeking candidates for a Faculty Position for Anesthesiology Critical Care, as well as a position with Providence Sacred Heart Medical Center, whose combined Departments of Anesthesiology and Critical Care are recruiting an Anesthesiologist to join its staff—at 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.

FEATURED ARTICLE

Increased Interest in Critical Care Among Anesthesia Residents During COVID-19 Pandemic

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The COVID-19 pandemic created a unique crisis in healthcare across the world. Due to the shortage of staff to cover surge intensive care units in many hospitals, the Society of Critical Care Medicine, among other organizations, recommended a tiered approach to forming surge capacity teams for coverage of additional critical care beds[1]. These models seek to extend the expertise and oversight of intensivists, and other critical care professionals, to a greater number of patients via a multidisciplinary team. Among these teams we have seen a remarkable effort by anesthesia residents volunteering for ICU shifts. This was irrespective of their post graduate year and level of training, or even future plans for further critical care training. Of our pool of residents, several volunteered for these shifts eagerly and of their own accord. When asked as to what the motivations for this were, some interesting aspects were brought to light. Some did it to relieve the pressure on the Department to staff these units, which was stretched thin in terms of manpower. One resident stated:

> ***"I was part of the second wave of residents deployed to the ICUs. My main motivation was to provide relief for my co-residents and share the burden. Many expressed how exhausting the ICUs were and I wanted them to have somewhat of a break from the toll COVID-19 was taking on the department."***

Others had a sense of duty and a desire to learn new skills:

> ***"COVID turned the world upside down and inside out. My willingness and motivation to work in the COVID ICUs reflects the spirit of the Hippocratic Oath; simply, it was the right thing to do. Patients arrived at the hospital in dire straits and in desperate need of help. No single provider should bear the responsibility of helping these patients and their families navigate the countless unknowns even when we may not have all the answers. From a training perspective, it was a rewarding and remarkable experience to practice a skill set under the guidance of experienced and knowledgeable intensivists. While we may be dealing with COVID for months and years to come, I am not sure if I will practice medicine with such extreme need for flexibility and creativity. If the need arises in the future, I feel better prepared to comfortably feel uncomfortable to use my knowledge and skills for a greater good."***

Whilst most found the challenge rewarding, the long hours and prolonged disease duration of the COVID patients made the work even more tiring, especially with the heavy PPE worn all day in most of these units.

> ***"For me, volunteering to work in the COVID ICUs was a pretty simple decision to help out in whatever way I could. We as a department were doing so much less OR work and I felt that in the middle of a worldwide health crisis, it felt strange for me to be less busy than normal. We are lucky enough to have ICU care be part of our standard residency training which made working in the surge ICUs an easy and obvious way to contribute to the cause. The experience itself was a bit of a double edged sword. I enjoyed the camaraderie of working with people in unusual circumstances, surroundings of a disaster-type situation. However, the nature of the disease meant long intubation and ICU stays with sometimes very little changing from day to day, which was depressing and brought out my most pessimistic side. In a way, I just felt like a ventilator baby-sitter some days."***

Whatever the motivation may be, this trend of residents volunteering for ICU shifts during the pandemic shows an increasing interest in critical care training and the rewarding aspect of rising to challenges and making a difference in times of global crises. This may resound deeply with the core of why we sign up to become doctors and the professionalism and altruism that is inherently linked to this field. We hope that in an age that may require an increased number of critical care staff in the future to run units, this trend results in more residents applying for critical care fellowships, and we must be prepared to accommodate these trainees by broadening the job pools as well.

REFERENCE

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WELLNESS

Physician Wellness During a Pandemic

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COVID-19 has caused immense stress on physicians. Anesthesiologists and critical care physicians have been at the forefront of pandemic response, whether caring for critically ill patients or facilitating surgical procedures amidst significant uncertainty. Health care providers are particularly vulnerable to mental health issues amidst risk of exposure, longer work hours, shortages of personal protective equipment (PPE), challenging resource allocation decisions, stress of caring for their loved ones, threatened financial and job security, and an overall decrease in social interactions.

When the pandemic hit the United States in March 2020, many institutions in metropolitan areas channeled their resources to manage these patients and canceled elective surgical procedures in response to either internal pressures or external mandates. These decisions materially impacted both patients in need of surgical procedures and hospitals who often depend on revenue from such procedures.

Physicians working in the U.S. with family abroad were, and largely still are, impacted by travel restrictions such that traveling abroad to support their families through challenging times was not possible. Some departments have been impacted by early retirements, and others have lost faculty members due to COVID-19. These and other challenges have only served to heighten the already-present risk of burnout. Professionally, many academic physicians have felt the deleterious impacts of restricted conference travel, fewer opportunities for in-person networking, constriction (or disappearance) of financial resources, shifting priorities for non-COVID-19 research, and increased family demands outside of work.

These uncertainties have also affected our anesthesiology residents and critical care medicine fellows. Some trainees have been affected by loss of job contracts, which had already been signed. The American Board of Anesthesiology (ABA) had to postpone board examinations, which are now being rescheduled to be held via an online platform. There is anxiety on their part surrounding how this is going to be executed, and more broadly they are particularly stressed about how these changes could impact potential career opportunities and their further career development.

Training program (and physician recruitment) interviews are also changing with growing adoption of videoconferencing and online interviewing platforms. This creates new challenges for program directors with limited time to adapt and make changes to the existing structure. At the time of writing, we are seeing a resurgence of infections around the world, and many countries are imposing fresh lockdown measures and other restrictions, which could create further challenges in the next few months, or even years.

We are most clearly dealing with a “new normal.” In order to stay engaged and deal with stress, setting up personal, intellectual, and health goals are important. Personal goals could include eating and drinking on time while on service, getting adequate sleep, adopting a hobby, or finding quality

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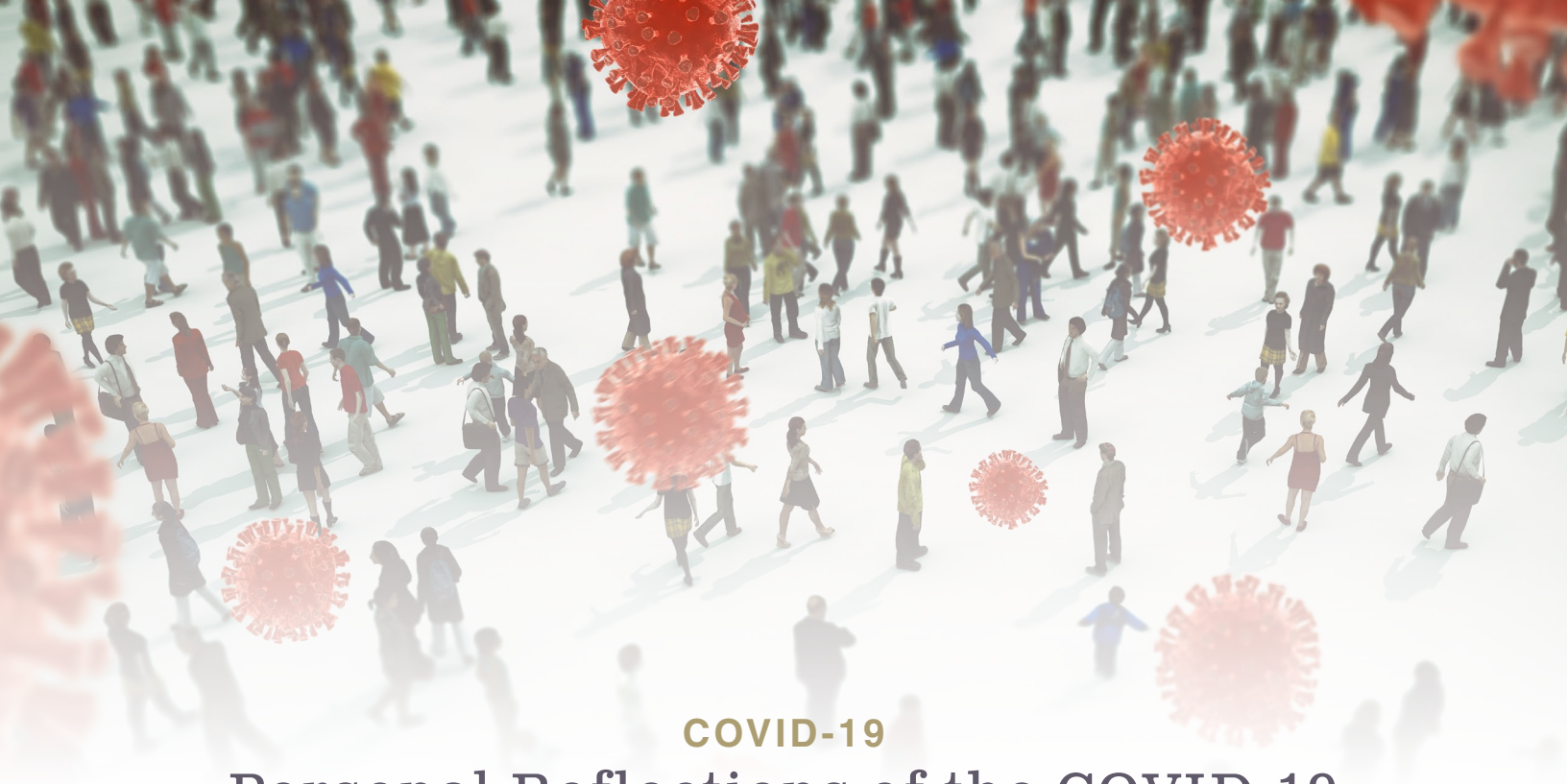
time to spend with loved ones. Achieving intellectual or professional goals is particularly challenging in the current environment, especially for critical care physicians in a busy work environment. Departmental wellness committees can therefore help to serve the faculty by pivoting to address these needs in addition to other facets of well-being. These entities, in response to identified stressors, should help find innovative ways to promote fairness and help individuals meet their myriad goals. The reward will be a resilient organization with high job satisfaction among its employees. Wellness committees can also plan recreational and team-building activities that can be done safely in the current environment.

Online conferencing and networking tools have been a great way to interact both for well-being, professional development activities, and routine internal meetings. A significant portion of our departmental meetings and lectures at the University of Alabama at Birmingham (UAB) are now conducted through Zoom, which has been favored by the faculty owing to convenience, especially amidst a busy schedule. Our departmental information technology (IT) program helped transition many of these activities seamlessly to teleconferencing without burdening busy clinicians with logistics. Zoom is also now used by many to connect with family members, conduct virtual dinners, hold family meetings, and stand in for other social events. Our residency interviews are conducted over these online platforms as well, and we are using Twitter to showcase training program achievements and life in the city. We have successfully conducted online book clubs and virtual interactive breakout sessions via Zoom. Again, IT resources were critical to success here. Online tools, like concept board and live board, can be used for brainstorming sessions and sharing ideas.

While our physical mobility has been limited during this time, opportunities remain to pursue online degree programs, training courses, and professional development programming. It has also become increasingly easy to connect with our international colleagues by organizing webinars, particularly by creating YouTube channels that can be accessed globally. SOCCA has likewise taken steps to become a broader platform for knowledge sharing. Our webinars, growing presence on Twitter, and the SOCCA DocMatter community have all helped to bring together members and share ideas from experts in our field.

Maintaining health and well-being has become a challenge with social distancing measures. While some outdoor sports and recreational activities can be enjoyed outdoors with social distancing measures, indoor activities and gyms are facing issues with maintaining appropriate safety precautions. With a little effort, it is not very difficult to create your own workout space at home. I created one during the pandemic when my gym membership was cancelled and have thoroughly enjoyed the convenience.

As we adapt to this “new normal,” we should find new ways to work together and continue to push for the continued advancement of ourselves and our medical discipline. There is no doubt that we are under immense pressure, but we have come out of stressful times in the past more resilient and equipped with new skills and tools. Creating a supportive work culture has never been so important to alleviate burnout, such that we can continue to be the best possible co-workers and effective mentors to our trainees who are seeking to achieve their full potential amidst stressful times.



COVID-19

Personal Reflections of the COVID-19 Pandemic and Professional Development in Anesthesiology Critical Care

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The biting cold winter in Minnesota did not feel any different in January, 2020, but for the news wildly circulating over the internet, television, radio, and social media of a novel coronavirus spreading in the Chinese city of Wuhan, which would later be termed SARS-CoV-2. Everywhere else, people continued their life with minimal worry. In the new millennium, other potential pandemic threats related to SARS (2003), H1N1 (2009), MERS (2012), and Ebola (2014-2016) were readily managed with routine infectious disease principles and did not disrupt our life to any significant extent. The medical community was able to handle or extinguish those contagious outbursts at the local or regional level.

But by February 2020, COVID-19, the disease caused by SARS-CoV-2, erupted in the Italian province of Lombardy, triggering a temporal lockdown. Despite these measures, COVID-19 continued to spread around Europe and the entire globe. Country after country failed to contain the virus, overwhelming the unprepared international medical community to the point that the World Health Organization (WHO) declared a pandemic on March 11, 2020.

Meanwhile, my family just returned from a sunny vacation abroad at the beginning of March, where we were largely disconnected from the media and the evolving crisis. Upon my return, the first week in the ICU hurled me into the mix of rapidly changing COVID information. Less than a week from the WHO announcement of the COVID-19 pandemic, executive orders from the Governor of Minnesota mandated a lockdown, and the regional M-Health medical system halted all elective operations to reduce use of personal protective equipment (PPE) and reserve supplies for emergency surgery. Catapulted into the unknown, we confronted the uncertainty with a mixture of determination and anxiety. The apprehension of the medical and lay community grew exponentially. The lack of understanding of this disease, along with insufficient PPE and medical supplies, generated feelings of loss of control and stress about our well-being. At home, we felt trapped. At work, we felt insecure. Outdoors we felt safe but isolated. The community support gradually turned guarded by social distancing. The masks covered smiles, the voices sounded muffled, and touching was prohibited. Most clinicians experienced stages of grief at various cadences, vacillating between denial, anger, bargaining, depression, and acceptance.

The University of Minnesota Medical Center is part of the M-Health Medical system, including 12 adult (and one pediatric) hospitals. We received daily emails from our M-Health enterprise command leadership for most days April, May, and June. New policies were issued, and guidelines were written and updated frequently. The pace of change was dizzying. Representatives

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and members of our Department of Anesthesiology became actively involved in the operating room (OR), the Intensive Care Unit (ICU), and our system-wide response planning. Gradually the system email frequency became twice weekly and subsequently weekly. Our Anesthesiology department's chair, Dr. Michael H. Wall, prioritized open communication, team cohesion, and personal safety throughout numerous 'Zoom' staff meetings for faculty, trainees, nurse anesthetists, and administrative support personnel. The staff meetings offered ample opportunities to address questions.

By May, the focus transitioned to reopening plans. Delayed surgical procedures were now becoming urgent. We gradually resumed most surgical operations by mid-May. Surgical leadership created various tiers of patient interventions to prioritize patient needs. Meanwhile, the immediate and profound financial impact of COVID on surgical case volumes, hospital cash flow, and individual compensation became evident.

The month of July returned with the hope of a seasonal decrease in the number of COVID-19 cases. This proved partially true. The summer also brought new physical fatigue as we scrambled to resume "normal operations" with very abnormal procedures and practices. Leadership prioritized personal and institutional resilience. The frequency of staff meetings decreased over time, as we felt safer at our workplace and our clinical operations increased to near normal activity. Nevertheless, everyone's professionalism was challenged on many fronts. Our patients and our health care providers were confused by erratic COVID testing procedures and results. Some personnel got sick; however, most of us did not. The proper use of protective equipment and infection prevention rules worked for most of us. But as in pandemics of the past, nurses were most vulnerable and bore the brunt of COVID exposures at work.

What about psychological and emotional factors? The stoic medical community tends to deny burnout and intrinsic stress. This time the anxiety and trauma were undeniable; we had to learn to express our fears, confusion, and recognize the early signs of burnout. Each individual experience was unique, and yet there was a pervasive sense of community. Sometimes we felt anger. Nevertheless, compassion towards others and ourselves remained paramount. At the University of Minnesota, our Anesthesiology and Psychiatry Department joined forces and started a "battle buddy" program to enhance peer support, beyond just relying on friends and family.1 Our department is fortunate to have a well-established wellness committee covering key components even before the COVID-19 pandemic. This wellness committee became more active. However, some of us felt overwhelmed and showed meeting fatigue. The medical community, in general, sought to write and read more well-being literature. Authors concentrated on recurrent terms such as burnout, resilience, wellness definitions, and the quest for solutions.[2] Yoga instruction and cooking classes were not going to be sufficient to cope with COVID.

In this volatile climate, some found prolific ground for academic endeavors and medical research. I toil in the mid-career category aspiring for promotion. While my clinical reputation, education curriculum accomplishments, mentorship for residents and fellows, administrative obligations, services for local and national society committees, invitations to speak at local, national and international professional courses and conferences, and global health involvement are all significant, I am challenged with sufficient peer-reviewed scientific publications. This conundrum is well-known in the academic environment. Although I remain determined, I occasionally feel overwhelmed with the expectations and academic demands. I ruminate about current barriers to publishing more. I wonder why I was more successful both before my Anesthesiology residency in the US and during residency and fellowship training, but now seemingly less so as an Assistant Professor in Anesthesiology and Critical Care. Perhaps being an international medical graduate did not help my academic career launch since I had to do my residency and fellowship twice, first in Romania and the second time in the USA. Why is my stamina losing momentum?

Publishing in extenso manuscripts is a challenge for many researchers, with a non-publication rate of registered clinical trials as high as 27-66%, and rare disease studies remaining mostly unpublished.[3,4] On the other hand, many journals expedite the review and publication of COVID-19 research and make them readily available online.[5] It is therefore no wonder why some authors emphasize the requirement of rigorous research methodology and peer review during the pandemic, regardless of the medical community's urgent needs.[6] There is an intrinsic desire we have to understand and tackle the COVID-19 disease that poses so many risks to our lives and

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COVID-19

Pseudomonas Aeruginosa in 500 Words (and 5 Minutes): A Lesson in Dynamic Evolutionary Pressure

"How can I miss you, if you won't go away?" – song by Dan Hicks and the Hot Licks

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Particularly challenging in the chronically hospitalized, the immunocompromised, and those with cystic fibrosis, P. aeruginosa (**Figure 1**) has found a niche in intensive care units around the world. P. aeruginosa is a very common, encapsulated, gram-negative rod that has been recognized for its highly evolved antibiotic resistance. As a facultative anaerobe, it is ubiquitous in the environment – presenting in soil, skin flora, and touch surfaces – and thrives on moist surfaces. Its versatility allows it to inhabit many harsh environments, flourish in damaged tissues (e.g., lungs, urinary tract), and form tenacious biofilms on implants. As such, P. aeruginosa is implicated in 9-10% of hospital-acquired infections. Interestingly, pseudomonal growth in the respiratory tract can be virtually asymptomatic until the development of a biofilm, overwhelming the primary cilia movement of mucus, which is a phenomenon contributing to the morbidity associated with cystic fibrosis lung infection.

Figure 1. Pseudomonas aeruginosa. ID#23249 2019 Jennifer Oosthuizen CDC/Antibiotic Resistance Coordination and Strategy Unit. Public Health Image Library.

The genome of P. aeruginosa is comparatively large and plasmids are often present, many facilitating antibiotic resistance. Its multidrug resistance is predominately related to the development of three separate efflux pump mechanisms, particularly the MexAB-OprM multidrug efflux pump that effectively negates the activity of penicillins, cephalosporins, and aminoglycosides[1]. In addition, target site mutations in the GyrA topoisomerase subunit, a target of the quinolone class, may result in drug treatment failure. Carbapenem resistance results from loss of the outer membrane porin channel (OprD).

Its innovative adaptability results in high risk for antibiotic-resistant infection later in a patient's hospital course, including ventilator-associated pneumonia (VAP), particularly after earlier exposure to antibiotics[2]. P. aeruginosa comprises 10-20% of isolates in VAP in the United States and is often multidrug-resistant. Most patients will have an identifiable risk factor for P. aeruginosa hospital acquired pneumonia, such as prolonged mechanical ventilation, advanced age, antibiotics at admission, and local prevalence of P. aeruginosa[3]. Additional risk factors include structural abnormalities of the lung or a history of repeated exacerbations of chronic obstructive pulmonary disease. Gram negative antibiotic coverage has been extensively studied in VAP. Empiric regimens have included cephalosporins, antipseudomonal penicillins, and carbapenems, among others. Broadly, the research evidence has not suggested major differences between drug classes in mortality, adverse events, and other clinically relevant endpoints for the treatment[4]. This concept suggests that local environmental factors may play a considerable role in mortality associated with multidrug resistant organisms, such as P. aeruginosa. Clinicians should therefore familiarize themselves with their local institutional antibiogram to most effectively treat potentially antimicrobial-resistant pathogens. Furthermore, guidelines recommend that

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two antipseudomonal agents from two different classes should be utilized in patients with risk factors for antibiotic resistance (**Table 1**). Avoiding early inadequate antibiotic therapy is highly associated with improved outcomes in P. aeruginosa pneumonia in critically ill patients[5].

Table 1. Risk Factors for the development of Multidrug-Resistant Infection

RISK FACTORS – MDR VAP

1. Prior antibiotic use within 90 days
2. Features of septic shock at time of VAP
3. Features of acute respiratory distress prior to VAP
4. >5 days of hospitalization prior to VAP
5. Renal replacement therapy prior to VAP onset

RISK FACTOR FOR MDR P. AERUGINOSA

1. Prior antibiotic use within 90 days of VAP

Adapted from: Kalil A, Metersky ML, Klompas M et al. Management of Adults with Hospital-acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society (2016)

In conclusion, P. aeruginosa is an organism notable for its innovative and opportunistic abilities to wreak havoc in our intensive care environments. Treatment should focus on its rapid identification (including risk stratification), understanding local patterns of drug resistance, and treatment by tailored antibiograms to ensure favorable outcomes in our critically ill patients.

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well-being as a global society. Indeed, in a recently published correspondence, a group of researchers pleaded for a scientific consensus regarding the COVID-19 pandemic.[7]

Meanwhile, my inherent desire to participate continues. The University of Minnesota IRB approved my COVID-19 predictive model study at the end of April. I received access to two comprehensive clinical databases that will require programming, coding, mathematical analysis, besides statistics. These tasks seem challenging and complicated. How can I make a difference and be accurate at the same time? I chose to collaborate with a group of researchers from our University with various backgrounds in surgery, internal medicine, critical care, pathology, health care informatics, statistics, and infectious diseases. We meet via video chat, communicate electronically, share ideas, write together, keep each other accountable, and critique our work. We want to keep the momentum going with positive energy as a community.

My hope for solid progress has been restored, and I see a fruitful and rewarding academic future again. Thank you, my medical community companions, for struggling together and bringing positive resilience to this challenging time. I believe that the COVID-19 pandemic challenge will teach us wisdom on many levels, professionally and spiritually.

ACKNOWLEDGMENTS:
Richard C. Prielipp, MD, MBA
Professor of Anesthesiology, University of Minnesota Medical School

COVID-19

COVID-19 Intubations: 10.7% Risk To Healthcare Workers?!

A summary of … El-Boghdadly K, Wong DJN, Owen R, et al. Risks to healthcare workers following tracheal intubation of patients with COVID-19: a prospective international multicentre cohort study. Anaesthesia. 2020 Nov;75(11):1437-1447

Chris Varani, MD
Oregon Health & Science University
Portland, OR

Ryan J Fink, MD
Oregon Health & Science University
Portland, OR

The risk to healthcare providers of intubating patients with COVID-19 is a global concern, but data are scarce despite the presumably high risks. Surprisingly, the results of a recent study published in Anaesthesia by El-Boghadadly et al. suggest that the risk of transmission, hospitalization, and/or self-quarantine may be slightly higher than 10%[1]!

They present data from a prospective international multicenter cohort study based upon self-reported data in the new intubateCOVID registry. The registry includes data reported by 1,718 healthcare workers who reported 5148 intubations between March 23 and June 2, 2020. Roughly half of those intubations took place in the ICU. Of the participants, composed primarily of anesthesiologists followed by intensivists, 184 (10.7%) reported the primary composite endpoint: a positive COVID-19 test, hospitalization, or self-imposed quarantine for COVID-19-like symptoms. As the accompanying graphic shows, 3.1% of participants had a laboratory-confirmed positive test, and 2 required hospitalization. The cumulative incidence of positive endpoints increased over time.

Healthcare workers were greatly affected by the SARS-CoV-1 outbreak, representing 21% of infected patients. As we have learned how SARS-CoV-2 may behave differently, it is important to compare this current study to other available data, however limited. A recent study[2] found the incidence of a positive COVID-19 test was approximately 4% in front-line healthcare workers, compared to 0.33% for the general community. A study from Wuhan, China indicated that healthcare workers in high-risk departments, such as the ICU or the surgical department, had a higher risk of infection but was unable to quantify how much, if any, risk is attributable to airway management[3]. In a survey study of 105 anesthesiologists and intensivists at a New York City hospital[4], 61 (58%) reported a workplace exposure (mostly related to airway management), 26% of those reported COVID-19-like symptoms after that exposure, but only 12% of providers tested were found to be positive for antibodies. That was the same incidence of positive antibody testing for those reporting no exposure, and the authors concluded the COVID-19 infections were most likely community acquired. (Interestingly, antibody-positive participants were twice as likely to use the subway). More recently, two new studies using optical particle sizers and lasers from the UK[5] and Australia[6] suggest that intubation does increase aerosolized particles. Interestingly, the UK study argues against labeling intubation an aerosolizing event as compared to a cough.

This study is timely as we navigate this new disease, and the authors should be commended for rapidly developing and deploying this prospective study and database. They investigate a question with very little data: what is the risk to healthcare workers when performing airway management? Strengths of this study include its large, international reach (503 hospitals in 17 countries), and data collection is ongoing. The database contains a sizable quantity and variety of data, including an assessment of personal protective equipment (PPE) compliance. The database had enough follow-up data for over 5,000 intubations, adding to the validity of the data. It will be interesting to see how the data changes over time, especially with COVID-19 cases again rising globally. Finally, the COVID-19 pandemic has been fraught with PPE shortages. Depending on how long you've been wearing your current N95 mask, you may either find it terrifying that 12% of these intubations were completed without

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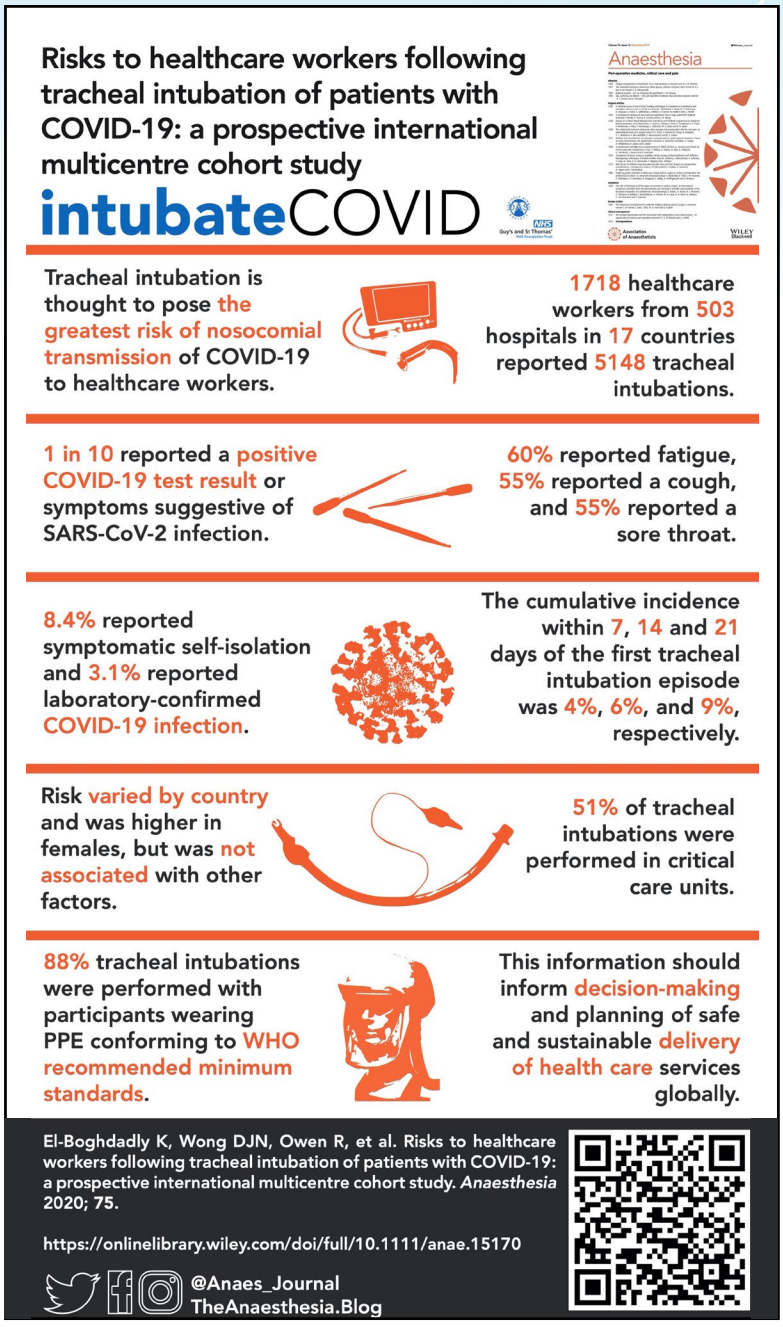

WHO-recommended PPE or be relieved that 88% of them did conform to current guidelines. There was no association with reporting the primary outcome and the PPE combination used, but this may be due to the vast majority of registry participants (88%) wearing some combination of the recommended protective gear. As the pandemic continues (or worsens), and PPE shortages potentially re-manifest, risks to healthcare workers who do not have recommended protective gear may become better known.

Weaknesses include self-reporting as the sole means of data collection, an unclear assessment of temporal associations between exposure and outcomes, and little assessment to external exposures. Reporting and sampling bias are certainly a concern. It is feasible that the self-reported data may overestimate the data – some of those who self-isolated but were not tested could have been negative. The authors discuss, however, the lack of widespread availability of asymptomatic testing means that it is possible the true transmission rate was actually underestimated. A wide range of incubation times have been reported for COVID-19 with a recent meta-analysis suggesting a mean of 6 days[7], and the authors here gathered data at 7, 14, and 21 days. The authors are clear that this study is unable to provide causality between intubation and symptoms, and it is possible the longer time intervals studied only permitted more external exposures and confounding.

An interesting follow-up study might be examining how to optimize testing for intubators. Only 54 providers had lab data confirming COVID-19 while 144 providers self-isolated for symptoms only. Both groups were removed from the workforce with significant impact to care teams and families. Might the varied symptoms and the hypervigilance of our providers lead to more self-isolation and resultant cost than is necessary? Could different provider testing schemes decrease the number of isolation days? As we face the colder months and a surge in cases, it is vital that we have some data to help us protect our staff and ensure the consistent availability of critical healthcare workers.

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MEMBER SPOTLIGHT

Gettting to Know...Jing Tao

Jing Tao, MD, Memorial Sloan Kettering Cancer Center, New York, NY

This month we are featuring Dr. Jing Tao. Dr. Tao is an anesthesiologist and intensivist at Memorial Sloane Kettering Hospital in New York. She is originally from NYC, completed residency training at the University of Maryland, and then her critical care medicine fellowship at Brigham and Women's Hospital. We asked Dr. Tao to reflect on her experience as a SOCCA member so far.

How long have you been a SOCCA member?

Since 2012.

What is your favorite part about SOCCA?

I like that it is a small group, which makes it easier to manage and navigate. It is less daunting than SCCM, for example.

What are you hoping to get out of your membership?

SOCCA was one of the first professional societies I joined, and I recently started serving on the membership committee. I hope to learn more both about how professional societies operate and help contribute to the growth of this organization.

Why did you choose critical care?

I have loved being in the ICU since I was a medical student. It amazed me how well and how easy it was for intensivists to manage the sickest patients in the hospital. I also love the interdisciplinary management and human interaction that comes with each patient. It is also a nice change from the typically solitary work of an anesthesiologist.

What are your special areas of interest?

Blood management, factor concentrates, and the use of viscoelastic coagulation testing to minimize blood transfusion.

What are your hobbies outside of work?

Cooking, baking, and traveling.

What was the last place you visited?

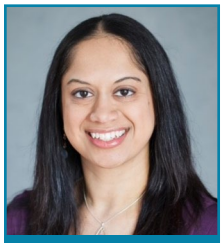
I had a trip booked to New Zealand in March, but it was canceled due to COVID. I am currently in Maine to see the fall colors!

What is your favorite food?

I eat everything! There really is not a food item that I do not love.

Tell us a fun fact about yourself.

This is slightly weird but fitting for the times — I am an immigrant originally from Wuhan, China. It is a large city in central China that no one has ever heard of...until now! It will probably be famous for a long time to come.



Interview conducted by:
Alisha Bhatia, MD
SOCCA Membership Committee Vice-Chair
Rush University
Chicago, IL

SOCCA has partnered with the International Anesthesia Research Society (IARS) and DocMatter to create a member community for high-quality, clinical discussions, especially to help in sharing your COVID-19 experience, ideas, and questions.

SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS SOCCA

SOCCA DocMatter Community

Learn more, sign up, and login to SOCCA DocMatter Community!

Available to you as a benefit of your SOCCA membership, DocMatter is a networking platform tailored to the specific needs and requirements of the medical community. This partnership will be particularly relevant to connect with members at other institutions during this pandemic.

Through the SOCCA DocMatter community, you will be able to:

- Gain access to full information from the frontlines
- Collaborate and strategize on how best to prepare and meet the demands of this global health crisis
- Participate in a broader, 30,000-plus member Global COVID-19 Community
- Connect—not only with fellow SOCCA members—but with members of other anesthesiology groups from 8,000 institutions across the world

A Brief Conversation with … Jeanine Wiener-Kronish

Jeanine P. Wiener-Kronish, MD, Henry Isaiah Dorr Distinguished Professor of Research and Teaching in Anaesthetics and Anaesthesia; Massachusetts General Hospital, Boston, Massachusetts was the 2020 SOCCA Lifetime Achievement Award Winner

How did you become interested in Anesthesiology and Critical Care?

As a medical student, I decided that I wanted to be an intensivist. This occurred because of my experience in the San Francisco General Hospital ICU with Drs. John Murray, Philip Hopewell and Sharon Rounds, who were faculty and a resident during my rotation. They were pulmonologists, so I trained in internal medicine and specialized in pulmonary medicine. When I finished training, I was the 2nd female Pulmonary fellow to complete UCSF training. I had done 4 years of research and had gotten a grant, but the division Chief of Pulmonary Medicine felt that as I had not trained in his lab, and as I was married, I didn't need a salary!

To find other options for employment, my colleague suggested that I consider re-training in Anesthesia so I could work in the Moffitt Hospital ICU, whose director was an anesthesiologist. I met with the new Anesthesia Chair, Ronald Miller, and he promised to support me in a research-faculty position if I re-trained. I therefore completed an anesthesia residency, and it proved to be the best decision of my career. The message is you should work with chairs and leaders who are supportive of your goals.

Who were the people that supported you in your career? How did you seek out effective mentors?

I had a lot of different mentors depending on the phases of my career. For research, my mentors Michael Mathay and Dara Frank (microbiologist/Basic Scientist) were very important. For clinical work, I would say Ronald Miller and Neal Cohen were very important. And when I became Chair of Anesthesia, other Chairs were very important mentors. When I became the chairperson at MGH, I had five different Chairs call me and offer their help.

Depending on what goals you have, you want honest feedback. It's hard to hear that you are not doing it right; if I could say anything to young people, it would be to be open to honest feedback. Do not be defensive, and attempt to continuously improve.

You have been nominated for the Chancellors Award for Advancement of Women (1998 & 2001) and received the Elizabeth A Rich MD Award from American Thoracic Society (2000) for mentoring women; what made you passionate about this issue?

My retraining led to a successful career—but men in my fellowship group did not have to retrain. My mother was a 2nd World War widow and had to be a single mother for a while, so I was raised with the idea that you need to be independent and strong. I saw women colleagues suffer and give up careers when they had children with special needs.

I have been very lucky; I have a great husband; my parents moved to San Francisco to help me when I had a child… but not everybody has that support. I feel very strongly that women need assistance in their careers.

At Mass General, I arranged invitations for presentations for women to assist them in their careers. I had a male colleague say that this was cheating, and talks should only be offered to people who deserve them. The concept of merit as an objective metric is flawed. Expertise is important, as you obviously have to show your knowledge and education during talks. However, promotions, positions, including leadership positions, and invitations to give talks require being given an opportunity. I try to increase opportunities for men too, but women have fewer opportunities and different responsibilities.

Interview conducted by:
Madiha Sayed, MD
Cleveland Clinic
Cleveland, OH

What advice would you give fellows and junior faculty in our specialty regarding progressing in their career and balancing the demands of clinical service, research and family?

I recommend finding something you are passionate about and reach out to faculty working in those areas. Collaboration and relationships are very important.

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Research is an important method for improving patient care—it is an important feature of academic medicine. Research also gives you flexibility for your time, a full clinical service can be demanding. Working in the ICU reminded me of the importance of caring for patients as well as being knowledgeable, and it reminds me to be grateful for my health.

I saw that a lot of your research is focused on ARDS and respiratory failure ... what drew you to those areas of interest?

Doing research was part of the certification process to become a pulmonologist. I loved working in the research laboratory of Norman Staub, working with Michael Matthay Jahar Bhattacharya, and Michael Gropper and many others. ARDS was and is a challenge.

More research is definitely needed with more human-like models of the syndrome.

When you became Chief of Anesthesia at MGH what were some of the challenges that you had to overcome in your leadership role?

At UCSF half the chairs are women; that wasn't the case at MGH. It is very hard when there are so very few women in leadership. You want to be effective, which is not the same as being demanding. Finding a way to get people to agree with you and work as a team is an important skill. And those skills are not taught in medical school.

Being a chair is a really tough job now. Economics with the COVID pandemic have brought economic crises to some departments, as anesthesia services and hospitals depend on elective surgery for revenue. I thought I could help young people and increase diversity as a chair. I'm very happy that the person that replaced me is the first African American Chairperson at MGH.

Do you feel we as a specialty were prepared for the COVID 19 pandemic?

I felt we were prepared. We closed down the ORs for elective surgery, and those anesthesiologists came to work in the many new locations that were opened as "critical care units". We also used volatile agents to sedate patients with anesthesia machines – which turned out to decrease the quantity of sedation administered to COVID patients. I was grateful to my anesthesia colleagues who came to the ICU to help keep the anesthesia machines running.

What I learned was that we needed to be able to monitor many more patients, but there was a lack of equipment to monitor patient's remotely. We have gathered data documenting that the quantity of sedation the COVID patients received was 2 or more fold higher than what we usually administered. This led to increased durations of sedation, increased delirium, and we are now measuring long-term cognitive outcomes. We are working on grants to improve our ability to monitor patients remotely, to be even better prepared for the next surge.

We need to stress in anesthesia training that critical care is part of the continuum of patient care. We need to take ownership of sick patients – the sickest patient are "ours," and we need to be fully versed in the latest treatments. In some respects, I feel everyone should be Critical Care certified, but I am biased. Cardiac and Critical Care certification should perhaps be considered as ECMO and other cardiac devices are increasingly utilized. The COVID crisis really documented the importance of Critical Care Anesthesiologists.

What have you accomplished that you are most proud of?

Two individuals from my lab became chairs of Anesthesia and of Pulmonary medicine respectively. I know a lot of residents and fellows who I have worked with are now in leadership positions and are also doing well in research. You want your legacy to include people that are succeeding, in part because of your efforts. I am proud that I did help provide opportunities for both men and women to succeed.

At the AUA, we just started a leadership advisory board, the LAB, with Maya Hastie as it's leader. The LAB will provide networking opportunities and other skill sets. We want young people to participate and we want to increase the diversity in anesthesia. Ultimately, the goal is to help anesthesiologists succeed and be seen as key clinicians and researchers caring for perioperative patients, pain patients and critically ill patients.

IARS AUA SOCCA

ANNUAL MEETINGS

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Association of University Anesthesiologists

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The deadline to submit abstracts is Friday, January 15, 2021.

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2021

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Friday, May 14, 2021

Welcome from the SOCCA Board of Directors Chair and Annual Meeting Chair

Education Session I:
Leadership Beyond the Bedside in the ICU – The Leadership Shadow You Cast

Oral Scientific Abstract Session I

Education Session II:
Preventing Postoperative Pulmonary Complications – Are There Low-Hanging Fruits?

Lifetime Achievement Award and Young Investigator Award Presentations

Education Session III:
ECMO: Beyond Cannulas, Flow or Patient Selection

Oral Scientific Abstract Session II

Education Session IV:
A Look Back at the Surge: What We Found Ourselves Doing That We Never Anticipated

Closing Remarks

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SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS

VIRTUAL ANNUAL MEETING | MAY 14, 2021

Preliminary Program

Friday, May 14, 2021

Welcome from the SOCCA Board of Directors Chair and Annual Meeting Chair

10:00 am – 10:10 am

10:00 am – 10:05 am — SOCCA President
Miguel Cobas, MD
Jackson Health Systems, Miami, FL

10:05 am – 10:08 am — Annual Meeting Chair
Ashish K. Khanna, MD, FCCP, FCCM
Wake Forest University School of Medicine, Winston-Salem, NC

Education Session I: Leadership beyond the Bedside in the ICU - the Leadership Shadow You Cast

10:10 am – 11:20 pm

Moderators: *Megan Anders, MD, University of Maryland School of Medicine, Baltimore, MD and Christina Hayhurst, MD, Vanderbilt University Medical Center, Nashville, TN*

10:10 am – 10:30 am — Your Leadership Shadow in the Institution - Do You Understand Your Sphere of Influence?
Liza Weavind, MBBCh, FCCM, MMHC
Vanderbilt University Medical Center, Nashville, TN

10:30 am – 10:50 am — Navigating Leadership While Under-Represented in Medicine: Battling Imposter Syndrome and Staying True to Yourself
Meghan Lane-Fall, MD, MSHP
Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA

10:50 am – 11:10 am — Leading in Our Societies and Advocating for the Next Generation of Intensivists
Sheela Pai Cole, MD
Stanford University School of Medicine, Stanford, CA

11:10 am – 11:20 am — Moderated Panel Discussion and Q&A

Break

11:10 am – 11:30 am

Oral Scientific Abstract Session I

11:30 am – 12:30 pm

1. Breakout Room #1 – 6 abstracts presented, 5 min for presentation/3 min Q&A
2. Breakout Room #2 – 6 abstracts presented, 5 min for presentation/3 min Q&A
3. Breakout Room #3 – 6 abstracts presented, 5 min for presentation/3 min Q&A

Session designated for ABA MOCA® Patient Safety CME Credit

4. Breakout Room #4 – 6 abstracts presented, 5 min for presentation/3 min Q&A
5. Breakout Room #5 – 6 abstracts presented, 5 min for presentation/3 min Q&A

Break

12:30 – 12:40 pm

Education Session II: Preventing Postoperative Pulmonary Complications - Are There Low-Hanging Fruits?

12:40 pm – 1:55 pm

Moderators: *Aurora Quaye, MD, Massachusetts General Hospital, Boston, MA and Ana Fernandez-Bustamante, MD, PhD, University of Colorado School of Medicine, Aurora, CO*

12:40 pm – 12:55 pm	Mechanical Ventilation - Surgical Approaches are Changing Intraoperative Realties *Patrick Bender, MD* *University of Vermont Medical Center, Burlington, VT*
12:55 pm – 1:10 pm	Hyperoxia - When Good Intentions Lead to Bad Outcomes *Shahzad Shaefi, MD, MPH* *Beth Israel Deaconess Medical Center, Boston, MA*
1:10 pm – 1:25 pm	Residual Neuromuscular Weakness - Bundle up for Success? *Karsten Bartels, MD, PhD* *University of Colorado Denver, Aurora, CO*
1:25 pm – 1:40 pm	Detection of Respiratory Compromise Beyond the PACU - What are we missing? Ashish K Khanna, *MD, FCCP, FCCM* *Wake Forest University School of Medicine, Winston-Salem, NC*
1:40 – 1:55	Moderated Q&A

Lifetime Achievement Award and Young Investigator Award Presentations

1:55 pm – 2:55 pm

Moderator: *Robert Stevens, MD, FCCM, Johns Hopkins University, Baltimore, MD*

1:55 pm – 2:00 pm	Lifetime Achievement Award Introduction
2:00 pm – 2:20 pm	Lifetime Achievement Award Presentation
2:20 pm – 2:25 pm	Q&A
2:25 pm – 2:32 pm	Young Investigator Presentation #1
2:32 pm – 2:35 pm	Q&A
2:35 pm – 2:42 pm	Young Investigator Presentation #2
2:42 pm – 2:45 pm	Q&A

Session designated for ABA MOCA® Patient Safety CME Credit

2:45 pm – 2:52 pm Young Investigator Presentation #3
2:52 pm – 2:55 pm Q&A

Break

2:55 pm – 3:00 pm

Education Session III: ECMO: Beyond Cannulas, Flow or Patient Selection

3:00 pm – 4:00 pm

Moderators: *Angela Johnson, MD, University Hospitals Cleveland Medical Center, Cleveland, OH and Peter von Homeyer, MD, FASE, University of Washington, Seattle, WA*

3:00 pm – 3:15 pm Mobile ECMO: Integration into Hospital and Regional Structures
Vadim Gudzenko, MD
David Geffen School of Medicine at UCLA, Los Angeles, CA

3:15 pm – 3:30 pm Nurse vs Perfusionist ECMO: Pros and Cons: Considerations for Implementation
Joseph Meltzer, MD
University of California, Los Angeles, CA

3:30 pm – 3:45 pm Just Because You Can, Should You? Emotional Burden of ECMO Programs
Anahat Dhillon, MD
University of California, Los Angeles, CA

3:45 pm - 4:00 pm Moderated Q&A

ASA Update

4:00 pm – 4:15 pm

Dr. Beverly Philip, ASA President

Oral Scientific Abstract Session II

4:15 pm – 5:15 pm

1. Breakout Room #1 – 6 abstracts presented, 5 min for presentation/3 min Q&A
2. Breakout Room #2 – 6 abstracts presented, 5 min for presentation/3 min Q&A
3. Breakout Room #3 – 6 abstracts presented, 5 min for presentation/3 min Q&A
4. Breakout Room #4 – 6 abstracts presented, 5 min for presentation/3 min Q&A
5. Breakout Room #5 – 6 abstracts presented, 5 min for presentation/3 min Q&A

Break

5:15 pm – 5:25 pm

Session designated for ABA MOCA® Patient Safety CME Credit

Education Session IV: A Look Back at the Surge: What We Found Ourselves Doing That We Never Anticipated

5:25 pm – 6:40 pm

Moderator: *Nicholas Sadovnikoff, MD, Brigham and Women's Hospital, Boston, MA*

5:25 pm – 5:40 pm	Palliative Care on the Front Lines of the Surge *Rebecca Aslakson, MD, PhD, FAAHPM, FCCM* *Stanford University School of Medicine, Stanford, CA*
5:40 – 5:55 pm	Stretching ICU Spaces, Equipment and Personnel to Accommodate and Unprecedented Patient Volume *Vivek Moitra, MD* *Columbia University Medical Center, New York, NY*
5:55 pm – 6:10 pm	ECMO for the Epidemic -the Good, the Bad, the Lessons *Michael Nurok, MBChB, PhD, FCCM* *Cedars-Sinai Medical Center, Los Angeles, CA*
6:10 pm – 6:25 pm	Importance of Networking during a Global Pandemic *Allison Dalton, MD* *The University of Chicago Medicine, Chicago, IL*
6:25 pm – 6:40 pm	Moderated Q&A

Closing Remarks

6:40 pm – 6:45 pm

Session designated for ABA MOCA® Patient Safety CME Credit

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