Podcast Introduction and Guest Background

Welcome to the Doctors Making a Difference podcast where we help physicians to be empowered with the tools they need to be successful in medicine, in finance, and in life.

Join us as we highlight doctors and other professionals around the world who are making a difference. I am privileged to welcome Dr. Nan Nessel. Dr. Nessel is a pediatrician who spent years in traditional pediatric practice.

She's transitioned a little bit over to hospitalist type medicine with locums and she does a lot of coaching. Nan's a fascinating person. I think you're going to find this conversation interesting and I appreciate you being here.

Nan, would you mind introducing yourself to our audience? Thank you. I'm Nanette Nestle. I'm a board certified pediatrician currently working as a Locums pediatric hospitalist.

And I also am founder of the coaching company Beatdown Burnout. My journey in pediatrics started with me making the decision that I didn't want to be just a general pediatrician.

And I ended up going through a fellowship in medical genetics and then wanted to be in private practice. I didn't want to be in academia. So I found a place where I was able to do both.

And I was hired, or as I was told by the other pediatricians, specifically to start helping them build their pediatric subspecialties. Medical genetics doesn't make a whole lot of money.

And this was a very large multidisciplinary practice. I think at the time we had 60 physicians. Oh, it was very large. When I left there, we had 120. Now, only six to eight of us were pediatricians.

And administration was all for the subspecialty thing until they realized that medical geneticists don't make any money. And we don't bring money into the clinic.

Pediatricians in general don't bring a lot of money into a large clinic like that compared to, say, orthopedic surgeons. And this was back in the 1990s.

The top earner in the clinic made over $6 million a year. Goodness. And our pediatricians were making about $120. So a huge spread.

Career Path from Pediatrics to Locums

So it was a huge expense. Huge spread. Yeah. Primary chair, we didn't have anyone in primary chair making over 250,000. And we didn't have any subspecialists making less than half a million.

So there was a real big divide in it. It was a problem. But I managed to work my way up to chairwoman of the department, both at the clinic and at the nearby hospital.

But I was constantly a target because I wasn't bringing in the kind of money they expected because I did the medical genetics one day a week in addition to doing the pediatrics.

And so I got bullied by administration and eventually I'm like, life is too short. In addition to that, general pediatrics is hard. We were expected to be in the clinic eight to five Monday through Friday.

Most of the doctors took one day off post-call, but I didn't get that day off because that was the day I was doing genetics. So I was working the same number of hours in practice that I was working as a resident.

I was working a little over a hundred hours a week. I missed my daughter's first dates, first dances, helping her get ready for those things. I missed my son's first lead in a school play.

And I didn't want to continue that kind of life. So I ended up leaving there after I stepped down from the chairmanship and tried a solo practice. moved back home, and I didn't realize how competitive that was.

So that didn't last long. Tried a couple of other things, but eventually in 2012, I started doing locums pediatrics. And I would just go wherever they sent me.

It was a lot of rural places, and most of it was, again, traditional pediatrics. But when you're a locum, You're not working 100 hours a week because they're paying you hourly or daily.

So the hours were definitely better. The workload was better. I wasn't being pressured to see 36 patients a day. And so that was great. But again, I still wasn't really happy with it and I couldn't fully understand why.

My recruiter kept pushing me to try just being a Peds hospitalist. And when I did that, I found out that I was much happier just taking care of the kids who were in the hospital rather than doing all the office.

Office work is great for some people, but for me, It wasn't what made me happy and having the same conversations over and over and over again. I think being unhappy, being frustrated, being bored with what I was doing.

Whereas when you're in the hospital, you have no idea what's coming in the door. And my favorite thing is to do the code. take care of the baby who comes out not breathing.

That's when I'm dealing with the kid who shows up in the ER in shock. That's what drove my happiness and my pleasure in medicine, is when I found that I could do just that, I was much more satisfied.

Much more satisfied. But along the way, I'd mentioned that I was getting bullied by admin in my first real medical job. And that continued to be a problem in several of my other jobs.

And I didn't know what drove that until I started looking carefully at past experiences and what put me into medicine. So I chose to become a physician when I was about seven years old.

I was burned in a fire when I was five. If you look closely, you can still see some little scars on my face. It took all the skin off my face, back up into my hairline, both hands, some burns on my chest.

And I was in surgery, plastic surgery, reconstructive surgery, three times a year from the time I was six or seven until I was in my twenties. Wow. And I chose medicine as a way of paying back the surgeons and the nurses who took care of me when I was younger, or that's what I thought.

What I realized much later was that was my safe place growing up. The hospital was where I felt safe. I was abused at home and I was bullied at school.

I mean, horrendously bullied at school. Even some of the teachers bullied me. At the hospital, that's the only place where I was accepted for who I am.

No judgment. And so that's what I thought medicine would be.

Burnout, Bullying, and Finding Hospitalist Work

You know, I got into medical school, I found it's not that at all. It's, it's grueling. I don't know if your audience knows what the term pimping means, if they're mostly physicians, they do, but there's, yeah, there's, you know, the whole systematic thing of keeping you sleep deprived, tearing you down, making sure that their belief is that all of this will help these things like codes become automatic.

so that you can do them in your sleep. And really what it's doing is it's giving a lot of us imposter syndrome. And it certainly doesn't feel like a safe environment.

And I noticed the people around me also being bullied. It was primarily people who didn't look like everyone else in the community. So docs who were foreign med grads, docs who were women, docs who had some sort of birth defect or scarring, docs who spoke with an accent that was different.

So someone from Louisiana or the Carolinas who comes up to Chicago to work, clients and patients aren't comfortable with them because they talk differently and then they get bullied by their colleagues because they're not pulling the same weight and all of this happening and I ended up in a place where I was recruited to work at a small rural hospital specifically for my expertise at newborn resuscitation and my ability to stabilize babies for transport.

They wanted that and they wanted me for that and I was eager to go. I was really looking forward to it. The first few months there, it was fantastic. We had a really great team.

They communicated well. They lifted each other up. Everything was very positive. But what I didn't know at that time was almost all of our staff were travelers or temporary.

And as they were replaced by permanent people, we ended up with a charge nurse who, the way she felt important was to tear other people down. And she would argue everything I did.

She argued every order I wrote. When I would go around with patients in the morning, she would contradict me in front of patients, or after I finished rounding, she would go in and contradict everything that I had said to the patients in terms of teaching families how to deal with their newborn.

And it got to where she even started withholding critical information on the moms that I would need to be able to manage the delivery. It got very uncomfortable.

And a friend of mine who is not in medicine said, look, there's this coaching course coming up. It's basically a work show. It's free. You come every Thursday night for six weeks.

See if you can get anything out of there that's helpful. And I did. It was a complete mindset change for me in terms of what the possibilities were. I signed up and became a coach.

And in my first coaching course, about halfway through the eight-week course, I began communicating differently with this church nurse. I began communicating with her based on her personality type and her values.

And all of a sudden, she didn't know how to respond. She didn't know how to pick apart anything I did because I was agreeing with her basic values and communicating with her that way.

And basically, I shut down the unit pulley in three days. And this is one of the things that I talked about in my Ted talk is how everyone in that unit was being bullied and how it was driving health issues for the staff.

We had a number of staff who went from being overweight to morbidly obese, just dealing with dischargers. Almost everyone was on antidepressants or anti-anxiety meds.

Thank you, excuse me. And once we changed how we communicated with that one person, within three or four weeks, people started coming off of those medications.

They started lifting each other up, working better together as a team. We were better able to handle the high risk deliveries because communication improved.

And I then began going out and doing this at other hospitals. It's interesting how much all the way through, what we learn. I mean, you've noticed this when you've taken jobs or when you've been part of hiring or things like that.

You can teach people to do stuff. You can train an intelligent person to learn the skill, learn the practice. But the personality and the way we interact and various personality disorders that sometimes find their way into people in management, Those are very hard to train.

That's why we do in-person interviews when we talk to people generally before hiring and try to get a context of what they have done before because they may possess the skill, but you need to make sure that we're not going to have such a personality clash that we can't work together.

You found that and it sounds like you're coaching. Yes. Personal coaching that you received and then coaching you were able to give to others. help to manage some of those things.

Because dealing with, I always tell people, learning stuff is hard, but totally doable.

Childhood Trauma and Medicine as a Safe Place

Dealing with people is perhaps the most difficult thing we do in this life. And we learn to love people, but there are some real challenging folks. That's part of every job for sure.

And admittedly, my communication skills and my ability to deal with other personalities has improved dramatically on this journey. But if you look at personality types, Administrators are one personality type.

Surgeons are another personality type. Nurses are another personality type. And so we look at all this and when you understand that and understand there are keywords that go along with communicating based on your values, you can communicate more effectively with anyone in any of those groups.

And I spend a lot of time teaching doctors and nurses how to communicate with administrators Because when you can communicate effectively with them, you regain your agency.

Along this journey, I also learned that there's so much more to it than personality and communication. In healthcare, every one of us has trauma. I went into it because of my trauma, but every one of us has had trauma since going into it.

The patient that we couldn't save, the family that no matter what we did, they couldn't be pleased, confrontational visits in the ER in the middle of the night because they don't know you as their physician.

You're just the doctor on call and all these things. And then you throw in, in my career, I've dealt with two pandemics. We had the AIDS epidemic when I was in training and then COVID and all the emotional charge to dealing with both of those.

If you've practiced to write either of those, you've got trauma from them. And so I've added trauma coaching to what I do. And what I've learned is when you deal with the trauma and go to the root cause of that, all of a sudden people aren't getting triggered at work.

Now, we all know doctors who walk around triggered all the time. They're angry, they're resentful, they tend to overreact to things. And it's not just physicians, it's in every level of healthcare we see this.

But when you go back and you release that, they're able to say, oh, yeah, I feel a little bit triggered, but I'm acknowledging that and I'm moving on and not gonna let it affect.

how I deal with this other staff member. I'm not going to throw things. I'm not going to raise my voice. I'm just going to acknowledge that, yeah, that's what I feel.

But I can choose to respond in a manner that's going to move things forward and be better for the patient, better for me, and better for the team. And so that's my goal is to get people communicating that.

Oh, yeah. It makes a big difference. And we talk about, sometimes we just talk about outcomes. And I think as we reflect back to my medical training, it's a lot of goal-driven achieve this outcome at all costs, no matter what.

And sometimes it was like personalities and personal human needs to be able to sleep. All that stuff is put aside so that you can accomplish the mission, the purpose.

But the farther I, the more I've done this, the more I've realized that how you do stuff matters almost just as much, if not more than the outcome. Because you can get an outcome.

I mean, the classic example I tell my patients is you need to be able to trust the surgeon before you go to surgery, if it's an elective case. So if you go to a surgeon, I had one just the other day that I was talking to this really nice patient of mine and she had seen a surgeon and they were just not on the same wavelength.

The surgeon recommended a big surgery. And I said, well, probably that's the correct surgery. But she was just like, we are not on the same planet. We're not communicating.

And I said, well, you know, that that's an important thing. You need to stop right now and we'll find another surgeon because if you don't have that trust before you start the case, the challenge is when you have a complication, which almost everybody has some issue or question or something that comes up.

you're going to say, I shouldn't have gone to that rotten surgeon. They'll blame the personality rather than the procedure. And interestingly, this lady did go see another surgeon who recommended the identical procedure and had just probably have the same type of outcome, but she's immensely pleased with how it went.

She was delighted with the interactions and now she's in the recovery mode, but she's just speaking in terms of gratitude and Thanksgiving and all that kind of stuff.

Whereas with the previous surgeon, for whatever reason, there was just kind of a personality mismatch or maybe the surgeon was having a terrible day or didn't make her seem like she was important.

But how we do stuff really matters for sure. And we all have terrible days. And for me, I had a lot more terrible days when I was doing outpatient medicine.

I had days where I was expected to work through lunch just to get caught up on charting so that I could then get behind again in the afternoon and stay till six or seven o'clock at night getting all the charting done.

I had days where certain doctors would dump all of their patients that were complicated or if they didn't get along with the family, they would just dump those on me because I was the new physician for quite a while there.

And then the whole thing about immunizations, I know it's in the spotlight now, but that's something that's been an issue for my entire career, and I've been doing this almost 40 years.

Parents coming in and becoming very confrontational, we bring up the subject of vaccines. I bring vaccines up. early before they ever get, well, they get the hepatitis B in the hospital.

Some of them do, others wait, but I give them all the information.

Coaching, Communication, and Team Dynamics

These are the potential side effects. This is why we do this, all of that at like their first or second visit. And I ask them to go through it, write down any questions you have, research it on the internet.

And when you come back, we'll have a discussion. And there are families who throw that stuff away and then come back and yell at me because they feel they didn't have the information they needed.

And that was happening so often that and families demanding antibiotics for every little cold their kids got in antibiotics would help cold. So it's a lot of education of families.

And that just got to be very taxing for me. And when I transitioned into. Being a Peds hospitalist, I was so much happier. When your child is sick enough to be in the hospital, you're less likely to argue with the doctor about every nitpicky little thing.

You just want your kid to get better and go home. And so in that dynamic, I really thrived. And I was much happier doing that. And here's the thing, Pete's hospitalist was not an option when I finished my residency training.

There was no such thing as a pediatric hospitalist. This is a new field. And when I talk to younger physicians, I tell them, you know, you don't have to decide today what you're going to be doing in 20 years.

But you do need to stay on top of your CME and your education so that when the time comes to pivot, you're ready for that and you're able to do that. Well, I think it's interesting to reflect on all this stuff because, and it's also interesting, Nan, just thinking about you and your expertise and interests, you know, not everybody would rather run codes and deal with toxic, ill children.

I think a lot of people would think like, well, that's the hardest part of my job, but you found that you made a huge Yeah, you liked helping people in those settings.

You were able to make this huge difference and help people in a moment of crisis. And when you are the parent of a child who's going through that, you're just beyond gratitude.

So thankful for someone that has that skill set and has honed that craft so that when the time came for their child, to need help. It wasn't, they weren't just a number, they were the person who received expertise and care right then and there.

So kudos to you for your expertise and your love of that, you know, very acute side of pediatrics. And I've often wondered, why do I love this so much when everybody else avoids it?

And I think for me, when there's a code situation, you get a rush of adrenaline. I don't, I think I get a rush of dopamine. I think it hits all the buttons of reward for me.

And I bring this up because I do a lot of work as a coach with neurotransmitters. When you're under stress, you get elevations in cortisol and adrenaline, and that can lead you to that fight flight, fawn response.

When you're not in stress, you have elevations of things like oxytocin, dopamine, and serotonin. And I work with my coaching clients to help them elevate those oxytocin, dopamine, serotonin levels so that it balances out the cortisol and adrenaline, and it brings them calm, peace of mind, happiness, joy.

And this led to my TED Talk in Italy in May. I gave a TED Talk on how to flip your neurotransmitters so that when you are in stress and you recognize you're in stress, there are certain things you can do that will raise these other three neurotransmitters.

And the one thing that raises all of them is social interaction, positive social interaction. So I encourage people in all the different hospitals I've worked at to socialize with your coworkers and colleagues outside of work.

Have a time when you go out for pizza together or Chinese, even the times when you all do a potluck and bring things in, all of that is positive social interaction and is going to raise those positive neurotransmitters so that you feel better about being there and you feel better about being with those people.

And that can break down the barriers in communication. No, it's a good point. I often tell patients, I would say this comes up most when we're talking about food addiction as it relates to, you know, people want to lose weight.

And I always say, well, ask the question. You know, if you've already eaten and it's time for a snack, are you feeling that because you need dopamine or because you need nutrition?

And because that's a way to achieve dopamine. But I always tell people the 10-minute rule, take a drink of water. wait 10 minutes, do something else and come back and say, do I need nutrition?

If so, eat something for sure. If you need a dopamine, do one of the things you just said, Nan, call somebody, interact socially with somebody, write a letter to someone you love, do something that helps you take a walk, go get some sunshine, do something that releases dopamine.

And I think you've hit on a really key point. We've used all these other things to achieve the elevation of those positive neurotransmitters, but there's a lot of things that are negative, like overeating or doom scrolling on Facebook or whatever it may be.

Trauma Coaching and Neurotransmitters

But we have to kind of find things that are helpful to actually establish social connections. And that's a really powerful tool. If you know your people that you work with and you care about them on a level that's not just whether they fulfilled an order or did something at work, you're less likely to lose your temper with them or lose your patience.

And that's pretty powerful. So I'm glad you're doing that. Yeah, absolutely. You give them a little leeway, you actually try to see things from their point of view, and it raises the emotional intelligence of the entire group.

That's a good idea. Well, I wanted to backtrack for just a minute on something you said. I'm thinking about medicine, and I think people who are in medicine right now have the stewardship.

We're carrying the load, we have that baton, and we will someday pass it on to the next generation. And one of the goals that I think of is, how do we leave medicine better than we found it?

Because we beat up our doctors, and we have this system where you must go through residency, and especially the early part of a career, and you have to work an incredible number of hours with a lot of responsibility.

And there is still this kind of pimping mindset where you're giving people the opportunity to teach you back, but sometimes it's done really aggressively in a way that is shaming you rather than teaching you.

And then with that in mind, specifically pediatrics, you know, you talked about your experience in outpatient pediatrics was very busy and also didn't pay very much.

And you had colleagues that were making three or four, 10 times as much as you, uh, and perhaps putting in fewer hours. And so where do you see medicine going in the future?

Cause we need pediatricians. And if we discourage them all by saying, this is a horrible experience that you're going to have fewer people choosing that field.

I don't think you're going to like where I see it going in the future. Medicine is corporate. It is no longer a profession. It is an industry. And industries look at the bottom line as being financial and not outcomes.

So what I see in the future, and we're already seeing this in rural areas, is that your primary care physician will not be a physician. It will be a primary care provider.

It will be a nurse practitioner or a PA. And while those people are very good at what they do, their education is so much shorter than ours that there are some things that are not covered in depth like in our education.

And I don't know if that's entirely a good thing. But I know that in the state where I live, in small rural towns, there

are entire towns of 10,000, 12,000, 15,000 people where you cannot get a physician to be your primary care provider.

They're simply not available. And I think that's going to be the route that things continue. It's going to require good communication skills because I know that there are physicians who are specialists or subspecialists who don't want to take report from someone who's a non-physician.

So when the nurse practitioner calls and says, hey, I need to refer this patient to you, I'm doing a provider to provider consult, they get bent out of shape.

They have their prejudices. And so the hurdles we're going to find are, where are our primary care providers going to come from, and how are we as physicians going to interact with them?

Well, so what do you, you know, like, I think that you're describing the reality of what appears to be happening. And like you say, a lot of hospitals, a lot of the corporate side of medicine, which has to answer, which, you know, understandably has to answer for the bottom line and be able to pay the salaries of the physician or the nurse practitioner or PA.

But they also have to pay the salary of your, of the staff and the nurses and the receptionist and all the pieces of that puzzle. So in some ways, it's quite discouraging to say we aren't having people going into those specialties or they're not available, especially in rural areas, which is frustrating.

Do you have any ideas of things that we could do as a system to fix that? I mean, outside of correct the pay gap, which I think is something to be done on the federal level.

correct the pay gap, correct how insurance reimburses us, get rid of some of the barriers in getting the care our clients need, our patients need. I mean, the insurance barriers, the peer review stuff that all needs to be revamped.

And I would love to see us go to some sort of socialized medicine I don't see that actually happening anytime soon. I did part of my undergraduate career at Oxford University where I studied socialized medicine for a term.

The Future of Medicine and Primary Care

And yeah, it has its pitfalls, what every system does. But what you don't see are people not getting care. You don't see people going bankrupt to get care.

And so there's a lot less animosity between the patient and the physician because everybody's just focused on, let's see what we can do to help you. The high wage earners in socialized medicine don't make nearly as much as they do in the US.

So it's a system that does get rid of that pay gap. I just, there is so much prejudice against it in the US that I don't see it happening. I would love to, but I don't see it happening.

There's so many ideas of kind of what to do, but I'm a primary care doctor. I see people across lots of different age spectrums and across that big spectrum.

And I contemplate this and I say, well, when I'm done with this responsibility and pass the baton, who will take that? Who will come and say, okay, I'll be the primary care doctor that has this base of knowledge and can treat a variety of people and do it and our PA and nurse practitioner colleagues are wonderful and but I've I've kind of had some sympathy because a lot of times we've had people that come I'm in a rural area and they will come with just right after training and I see like wow you have had you know maybe maybe 400 600 hours worth of formal training and most physicians have you know minimum somewhere 12 000 to 15 000 hours worth of formal training and it's just a tremendous difference and so You take a really nice, intelligent person who goes through that training, and then we kind of put them out on their own.

In Idaho, where I practice, nurse practitioners can practice totally independently without any necessity of collaboration, which is challenging for the system.

But it's also challenging for that young individual who says, OK, I've completed schooling. and now they've kind of hung me out to dry in this little community and I can call somebody, but it's not the same as working in a team where you're in the same office and you're collaborating with a team of experienced physicians and people.

I think that was what it intended to be, but the reality in 2025 is an organization is financially incentivized to choose someone with a lot lower degree of training because it costs less, but I'm not sure it's always the best thing for our patients.

As we talk about this next generation of physicians, I want to get real personal here. I have two nieces who have gone this route and one of them has recently completed her training and is in her first real job.

She is a pediatric anesthesiologist. She was a nationally ranked athlete in college, very much a go-getter, very dedicated to everything that she does.

And that was the niche she found. She wanted to do anesthesia, but as she did anesthesia, she found she really enjoyed the pediatric anesthesia. And so she has found her niche.

Her younger sister, I'm just not sure about. She has that go-getter personality, and she's very dedicated to things. But she thinks that she's not looking at the financial aspect of it.

She wants to do what you've done and go into family practice. And I know her well enough to know that she's not going to be happy with the hours, and she's not going to be happy with the reimbursement.

But what I do see that's different for these younger kids, they're getting coaching from the beginning. So they are going to have help figuring these things out when they get to those barriers and those stumbling blocks.

I know that the older one got coaching in internship and residency, which helped her figure out what she wanted to do. And there is coaching available for the young one in medical school, but it's more on how to just deal with the stress of everything they're going through.

Either way, those kids are coming out with better communication skills than we had, with a better ability to manage the stress of the job, and a better knowledge of where their boundaries are in terms of pushing themselves physically.

And I think that, nope. What I hope is that the folks who come after will have, like you said, some tools to kind of manage from a coaching standpoint so they understand how to interact with others.

And I hope that we incentivize people to become the kind of doctors that you and I have done, where you do this broad base of training and you care for a whole bunch of different people.

And I worry that a future day comes where that's not the case. And so I'm glad you're still doing it. And I'm thankful that you have been able to be in this space and do it.

I hope that not everybody has to leave primary care pediatrics and become a hospitalist. But at the same time, we need both things. We just, I think in general, we need more doctors and more people that have had that broad base of training.

And then we just, we have to find a way for people to not be eaten alive because working 100 hours a week, when you are trying to raise children of your own.

I mean, that's that's no fun at all. Yeah, well, you're right. Well, Nan, tell us a little bit, you know, this this we kind of wrap up here. Tell us what comes next for Nan Nestle.

Nestle, I always get your name wrong. I'm so sorry. Nan Nestle, tell me how it is. What comes next? It's funny. So I am 66 years old. and will be eligible for full retirement within a year.

And I plan to take advantage of that and transition out of medicine and fully into coaching.

Retirement Plans and Wellness Clinic

As you know, I just got back from a trip to Florence, Italy. I went there in May for the TEDx talk, met some amazing people and went back last week to talk to a woman I met.

She is the owner of a four-star resort, an internationally ranked four-star resort, and wants to build out her spa and wellness offerings. And we are in conversation about me running a wellness clinic, something that offers things like hyperbaric oxygen therapy, near and far infrared.

It's a huge step from medicine. But we're learning more and more about these modalities and how they can be used in wound healing and things like that.

She has two siblings who are plastic surgeons. The plastic surgery patients come to the villa for the first few days after surgery to recuperate while the swelling is going down before they go back out into their lives.

And I'm probably going to become a very active part of that. I will continue to do the coaching, particularly trauma coaching, because it has such a huge impact.

of my clients, but the opportunity to live at a villa where they make their own wine and their own olive oil and kick back and relax and only work, say 40 hours a week.

That is very appealing to me. Yeah. Think about, well, that's only a doctor would say that. Think about cutting back to only 40 hours a week. I dream of that day.

It's funny, but true. It's only, oh my goodness. I don't know what I'd do with myself if I just stopped working. I really don't. Right. Well, you can just decrescendo a little bit.

I like that. Well, Nan, thank you for sharing your journey, your perspective, your ideas. You've had this very interesting full career and I've really enjoyed hearing that.

And again, I hope people listening to this will think about this and say, well, how can we leave this a little bit better? What kind of coaching resources do I need if I find myself in trouble right now?

And what kind of things can I do to make it a little bit better for those who come behind? And Nan, I appreciate you going on this journey with me. Any final thoughts for our audience as we wrap up here?

Well, first, I'd just like to thank you for inviting me to be here today. It's been an honor and a pleasure. I've really enjoyed this. My advice or whatever for the people watching is if you're feeling triggered, if you're feeling overwhelmed, if you're dealing with unreasonable burdens at work, reach out for coaching.

It really does make a difference. Well, thank you so much, Nan. You keep in touch and good luck. I hope that you get to live your best life and go live in a villa.

That sounds amazing. Take care. Thank you so much. Bye. Thanks for tuning into the Doctors Making a Difference podcast. And thank you for what you do to help your patients and your community.

Your work truly helps so many people.

Closing Advice and Podcast Outro

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