Episode Intro and Guest Introduction

Welcome back everyone to Emergency Minute, episode 27. And if you've actually listened to the 26 episodes before this, congratulations, you get a prize.

But in all seriousness, send me a message on Instagram and I will shout you out on the next show. I hope you did enjoy the last show, my first video podcast on YouTube, Tales from the Pit with fellow EM physician Dr.

Anthony Gwines, also the founder of Solea Scrubs. I'm curious to see where everyone is picking up emergency minute. Are you still listening to the audio on Apple or Spotify, or did you switch over and join YouTube?

Shoot me a message at Dr. Jay Parente on any social media platform and let me know. Today, I'm incredibly excited and very grateful for our guest. Will Flannery, MD, is an ophthalmologist and a part-time comedian.

He moonlights in his free time as Dr. Glockham Flecken. a social media personality who creates medical-themed comedy shorts for an audience over 5 million people across social media.

He co-hosts the medically-themed podcast Knock Knock High alongside his wife, Kristin Flannery, who's also known as Lady Glockumfecken. Dr. Flannery's humor has been shaped by the tribulations of med school and residency and his experiences as a patient.

He is a two-time testicular cancer survivor, cardiac arrest survivor, then saved by his intrepid wife and her timely CPR. Initially used as creative outlet to cope with these health challenges, Dr.

Flannery's comedy has evolved over time to incorporate biting satire of the U. S. healthcare system, academic publishing, and interpersonal conflicts pervasive in the medical system.

So without further ado, please welcome Dr. Will Flannery, AKA Dr. Glockham Flecken to Emergency Minute. Ah, thanks, John. Nice to be here. It's great to have you.

Long time fan. Uh, you know, my, one of my favorite videos that you had done was the one with the emergency medicine physician. Um, you know, and you did that to be more specific.

That's fair. That's fair. EM consults was the one. Yes. And, uh, it's impressive how you. can like lock in on people's like idiosyncrasies and sort of the nuances of some of the things that we do, but you're not like an EM physician.

Like I find that fascinating about you because I don't know how you toe that line of making fun of other professions, but being respectful. Well, it's funny because like that one, that was actually really easy to do to avoid like, uh, making people mad because, um, the other person on the other side of the phone, cause I'm, I'm just, I'm just dressed as emergency physician.

I'm just talking to, you never see who they're talking to, right? You never see who my cares. So, so the joke, the butt of the joke is like whoever's on the other end of the line most of the time.

But I don't I don't really reveal that too much. So no one can really get mad at me because they don't really know if I'm making fun of them or not. If people get mad, then it's really on them for for, you know, doing the bad consults.

So yeah, I think it's hilarious. I've watched it several times. You're one of the few people that I can watch on social media, and I actually do laugh out loud.

Dr. Glockham Flecken Origin and Comedy Style

I know it sounds cliche, but especially because the way you depict EM physicians, like I got my energy drink here. I was going to ask you, yeah, what are your outdoor activities of choice?

Well, we just were hiking in Hawaii with the family. We did like four mountains. Well, there you go. Yeah, my little five-year-old's hiking up the side of mountains, so yeah, it was pretty funny.

Yeah, but I started off watching that show this morning, that video, just for some extra inspiration and some laughter. Um, do you ever, let me ask you something.

Do you ever, um, do you ever call two different, uh, like the, the, the, the hospitalists and the ICU physician down at the same time, just have them argue with each other over who has to admit the patient.

Does that, it's funny. Does that happen? So we have a, we have a, um, so we have a three call rule, right? So if I call, you know, internal medicine and they punt to somebody else and then I call surgery and they punt it back, I say, okay, listen, guys, this is the last call.

You guys need to figure this out, but somebody's taking this patient. So it's, it's a third call. That's when you flip the phone over and have them talk to each other on two different phones.

Exactly. It's always fun doing that. Yeah, that's right. So I guess the one question I had is, how did you come up with your handle, Dr. Glockham Flecken?

I mean, obviously it's got to be some sort of tie in with glaucoma. Yeah, it's always exciting when people who are not in ophthalmology ask me that because it's a very boring explanation.

So it's a, glaucomflexion is a real term in ophthalmology. It's like, it's an exam finding you'll see in patients who have angle closure glaucoma. But don't worry, I'm never going to ask you, do you see any glaucomflexion on the slit lamp exam?

That's never going to be a question that we ask you guys. But yeah, that's all it is. It's like these little grayish white flecks that show up inside the eye on the surface of the lens in patients who have angle closure glaucoma.

which is hilarious, obviously. I chose it just because it's the dumbest word in ophthalmology. I knew that I was creating a medical comedy thing. I was trying to build this thing up.

I was like, well, it's got to be kind of a silly name. I'm an ophthalmologist, so what's a silly word? So anyway, that's the boring explanation. But it's actually a great use of the term.

And it actually kind of fits your style on social media perfectly as far as some of the humor that you use and the satire. It's unique. But now, if any ophthalmology residents or anybody is looking, like, what is glockenflecken?

They'll just see my videos instead of an actual explanation of what glockenflecken are. So I've supplanted the real term in terms of Google search. Yeah.

I mean, congrats to your SEO, right? Like I, I, I crave for the day that somebody is Googling Dr. J parente and I'm at the top of that list instead of whatever a parente is.

So fair enough. So one of the things I did want to talk to you about on a more serious note is, you know, your experience, you know, I'm an ER physician, so I deal with life and death, CPR, literally every shift.

And I don't know that my family even understands that. Um, But you know, it's curious to see like to hear your story is incredible. So many patients that are in your position don't get to see us.

So tell me about the heroic efforts of your wife, who is the reason why you're here today. Yeah, you know, I had back in May of 2020, I had an out of hospital cardiac arrest in my sleep.

So I was, I was having agonal breaths, and which my wife is not in medicine, you know, and so she just knew like, it didn't sound right. I snore a little bit, but this was not like snoring.

And so she tried to get me to wake up and I wasn't budging, called 911 and Basically, the decision tree for like, what does a layperson do in that situation?

The operator basically asks a couple of questions like, are they able to wake up? And if the answer is no, are they breathing normally? Those are the two questions.

And if the answer is no, then you start chest compressions. You have to just assume that that's what's going on. Something happened and there's a cardiac arrest.

So anyway, that was what happened. And she did 10 minutes of chest compressions right there on the bed because I weigh a bunch, like 100 pounds heavier than her.

So she couldn't get me on the floor, which is where you're supposed to do. CPR on a hard surface. But no, she's right there on the bed for 10 consecutive minutes until EMS arrived.

Cardiac Arrest Survival and Co-Survivorship

And this is high to COVID, right? So that's why it took so long because they had to put on like three layers of gear. And, and eventually, you know, busted through our back door and which was locked, unfortunately.

And they, they shocked me a bunch of times and gave me a bunch of medications. I'm not sure what they are. I'm an ophthalmologist, but Uh, whatever they, whatever they gave me, it helped.

Uh, Amy Otero and I think it was one of them and, um, say, and got a rhythm back and took me off to the hospital where I saw probably one of your colleagues initially.

And then it pretty much immediately, you know, was taken up to the ICU and did a targeted hypothermia treatment for 24 hours. And, uh, it turned out she did a hell of a job with the compressions and I was neurologically intact, or at least as neurologically intact as I was to begin with.

So. Yeah, that's a fair point. That's a great ending to that, a very serious story. I mean, yeah, it was, you know, it's, we've been, you know, we go around and talk about this for a number of different reasons.

because a lot of times healthcare professionals, you don't hear about that side of the story. The person, the loved one who does CPR, the effect that that has on people.

Kristen and I, we both do advocacy around chest compressions and recognizing when to do that and how to do that and all that stuff. So that's a big part of advocacy that we do.

But the trauma of doing that is overlooked. We take for granted. That's a good point. That we're just, you know, just do it. Just do chest compressions.

Like, you know, because we've done it so many times, right? I mean, you've done it many more times than I have. It's been a while for me. Not a lot of cardiac arrest in the eye clinic.

Thank goodness. But we do take for granted that just do it. Just do chest compressions. Like this is how you do it. But doing that to someone and most likely it's going to be a loved one.

It's going to be someone you know. That is an incredibly traumatic experience. And so when we ask people to learn CPR, we need to be thinking about supporting those people when they do it.

And so we talk a lot about co survivorship, which is, you know, Kristin, my wife is a co survivor of, of cardiac arrest.

You know, it didn't happen. Her, her heart didn't stop beating, but man, that, I mean, I was just out.

I just woke up in the ICU. I didn't know what the hell was going on. Right. She lived through every single second of that trauma. And, um, But we don't think in those terms, right?

We're like focused on the patient because we have to be. But we also just need to be aware of the effect that this type of thing saving someone's life when you're not in healthcare, what kind of effect that can have?

It affects people in healthcare too, right? I'm sure some of those experiences stay with you. You're a little bit more accustomed to it, right? So it's another point of advocacy that we're trying to do.

Kristin's writing a book right now where she's going to talk a lot about co-survivorship. Uh, and you know, it just, just showing support for those people, you know, making sure, you know, you're taking care of the patient, but also you have this person that just went through this, you know, offering them some support, you know, do they need to talk to somebody?

Um, what can you offer them? Even if it's just like a warm blanket or something like that, those kinds of things really make a difference. Yeah, that's incredible.

And to be honest with you until about 30 seconds ago, I'd never even considered that second sort of layer as you talk about. And I think probably what people think about is execution.

You know, when there's that crisis in front of them, like, oh, is it, you know, 15 to two and what's the ratio and how many inches down? But you don't think about, like you said, this is a loved one doing a pretty sort of barbaric, you know, thing to another human being that is also their loved one.

You don't really think about that. They're cracking ribs. There are sounds that you hear that you don't normally hear. Not to mention that someone that you love underneath your hands a lot of the time.

And so it's a hard thing. Well, I don't think I need to tell you the survival rate for pre-hospital cardiac arrest is very low. About 10%. One out of 10. One out of 10 survivors.

One of my favorite podcasts I did was breaking down some of the inaccuracies in Hollywood and I picked like a handful of medical scenes from movies and stuff and I talked about like how they did this wrong or that wrong and you know the EpiPen and you know Pulp Fiction and just cool stuff like that.

It was actually a lot of fun but you know you know unfortunately Hollywood dramatizes this and makes it seem like they actually studied this and it's like 85% of the people that undergo cardiac arrest on TV actually walk out of the hospital, which is not anywhere near real life.

No, no. I mean, I was doing it as starting chest compressions as quickly as possible is always key, right? And then you want to get the defibrillator going as fast as you can.

I have a defibrillator now sitting right. I have a subcutaneous implanted defibrillator, but my wife still bought another defibrillator. So we have my own and we have an extra one in the house.

And she could just use that if you like misbehave or, you know, if you're not, you know, if you burn dinner or, you know, whatever. So that's right. Um, but it's a man, the, uh, just this, you know, what she went through, um, and what a lot of people go through.

I mean, her story is, is, is. is not unique in certain ways, but having this happen around COVID, like right at the peak of the pandemic, right? This was May of 2020. We didn't have vaccine, we didn't have, we barely had testing, right?

So it was just chaos, right? We were in lockdown and she showed up to the hospital, just to compound the trauma I

just mentioned that she's already had, right?

She shows up to the hospital and- Probably wouldn't let her back. They wouldn't. Yeah. So they told her that actually at first they didn't let her back, but then they looked at my information and this is what they told her.

They said, oh, you can go in because your husband is an end of life case. Wow. That's what she told. They told her at the hospital. And by the way, this was news to her, like hearing those words.

And so she eventually came into the hospital and was put in the radiology department because they're distancing and everything. and that cut her off from the rest of the world because it's lead everywhere.

She had no cell reception. She was just alone with her thoughts and waiting to hear something on me and was pacing around the trying to go different places in the hospital, which she was reprimanded for in the hospital because she was, quote, making people nervous.

And so it was just a combination of things. Those things wouldn't happen today, obviously, but there are so many little things when your loved one is going through a major medical event These little moments that just add up to an entire experience that someone has about the healthcare system.

We haven't gotten into the billing and receiving all those bills and dealing with insurance. All of those things add up and that it can, you know, one or two interactions with somebody in health care can really make or break how people feel about U. S.

health care. And so it's just I think good to be aware of that looking just not the patient, but the immediate vicinity around the patient. Yeah, definitely.

And I think something that we're poor at in the emergency room is we're good at the you know, resuscitation part and, and that kind of stuff. But you're right.

That second layer of the emotional trauma from the family is like, it's hard to, from my standpoint, because, you know, one of the hardest things for me is to deal myself with this, these traumas and the situation.

And then I have 35 people waiting for me who are all super pissed off right now because they've been waiting. The knee still hurts. They haven't had their X-ray and they can't understand why.

And so I have to just sort of like just you know, clean the slate and go start over again, like nothing happened. So, um, I get it. It's not easy. You got it.

You have an incredibly hard job and, and yeah, the, the healthcare system, it puts so much pressure on you and everybody else working in the, in throughout the hospital.

that it demands so much of your time and makes doing things like this much more difficult. I want to ask you something. After the cardiac arrest, once I got home, I would say a few weeks later, we ended up having a meeting with the first responders.

So the EMS folks that showed up with a couple of firefighters.

Healthcare System Critique and Prior Authorization

And one thing that really stuck with me is the fact that they will often drop people like me, drop people off at the hospital and don't get a lot of closure about what happens to those patients.

So I was just, I'm wondering like how easy is that to do, right? Or do they, are you able to, is there a process in place or a time when you're able to like, hey, you know, that patient you brought in earlier tonight or yesterday, you know, this is what happened.

Like, is that, because I do think that that's another thing that helps them because they see so many, the EMS folks, one out of 10 survive. I mean, they see like nine out of 10 who don't, right?

And so just hearing about the save, the one save that they got out of those 10, I think can just help them to just keep going and keep doing this incredible job.

But I, it's, it seems like the system is not set up to like give them that closure. I don't know. It seems kind of, I can't speak to all hospitals, but the community hospital I work at, I've been at for 18 years and I've been a director for almost 18 years.

Um, we definitely have a process in place for which we recognize, uh, those medics. We even like for the bad outcomes, of course, we also have like a debriefing that we invite them to just a chance for everyone to kind of talk it out.

Um, Like the pit, they did it on the pillow. I noticed that. Yeah, but like we just had a great save last week. And I literally sent out an email to everybody that would listen, including the CEO of the hospital.

I'm like, you guys got to hear about this paramedic and what happened. And so we recognized him. And so yeah, there's, we do try to do that. Maybe I'm more cognizant of it because I'm a director and I've been director my whole career, but I mean, those things matter.

And, uh, yeah, so the medics, those medics are the heroes because I, by the time they bring them to me, I'll be honest with you. for the most part, the outcome's already decided.

Either they're gonna make it or they're not. By the time they come to me. So it's obviously God and it's the paramedics. Yeah, a lot of stabilization happens in the field.

Exactly. They're trying to do what they can to get the patient alive to you and then you just try to keep them alive or resuscitate them the best you can.

That's such a hard job, man. Yeah, exactly. And I think, you know, one of the things that you touched on, which is actually one of the main reasons why I invited you to be on the show, you mentioned about the broken health care system, which I, you know, I have, this is my 27th episode for emergency minutes.

I have a very huge focus on discussing how broken the healthcare system is. I try to add some humor. I'm not nearly as funny or good looking as you, but I, I try to put that in there.

Uh, I did see your, your videos, uh, the way that you're able to sort of use humor, but just sort of shine this light on how horrible some of these like pitfalls in healthcare are with the insurance companies and every, It's it's actually incredible.

It's you know, I kudos to you. I don't know how you do it. Thanks. And you know, it is a broken system right now, isn't it? I think it's I think what helps is, you know, humor is disarming.

And so the, the gut reaction, you know, when someone starts talking about the healthcare system is just going to be anger and, and anger is okay sometimes, but it's also, it tends to not be like real productive.

Right. Right. And so I think by approaching some of these very complex, like topics in our healthcare system and, and, you know, trying to, and that's what I try to do is at least for the, For like the medical things, like fights between nephrology and cardiology, like that's very inside baseball, a lot of that stuff.

And I'm making that for physicians for the most part. Like that's who I have in mind. And then people just seem to like the character, the personalities.

But the healthcare videos, those are different. In my mind, I'm making those for the public because I think a lot of

us in healthcare, we already know the pain points, right?

We know a lot of this stuff, but it's so complicated that people outside of healthcare who don't have a background, who don't deal with this stuff like prior authorizations every single day, They just, they're not aware of it.

And so the public, what do they do whenever something doesn't go right with the healthcare system? They end up, they usually end up blaming physicians, right?

And you can understand why. We're the face of healthcare, right? We're who they see. And to them, we're the top of the totem pole. We're the top of the hierarchy.

Usually we're not. There's administrators, there's CEOs, there's people above us, there are people in insurance companies that are really making a lot of the decisions and all these things.

These videos are for the public and I try to just distill these complex topics down to something that anybody can understand. By using humor, Uh, it, it takes a little bit of the edge off of just anger, right?

I could just do a front facing where I'm just looking right at the camera and I'm just telling you how, how shitty all this stuff is. Right. But if, but if I address it with comedy, it's a little bit disarming, still gets the point across, but leaves people with it.

Oh man, that really does. That's really his kind of stuff. That's, that's awful. We should change that. I don't know if I explained that well, but it just applies a different tone to it that I think is more conducive to thought.

Yeah. And I think that's why it resonates with so many people. I mean, it resonates obviously with the healthcare professionals, but to your point, it does.

It resonates with the average Joe too, because my favorite video that you've done in this sort of light is the prior authorization trying to explain that to a non medical person.

I mean that that video is fantastic and and it's scary and sad and and all these other different you know adjectives that we can apply to it. Um but it it is I mean it's these prior authorizations and just I don't really deal with that in the emergency room but I deal with the aftermath if that makes sense um because we get it all the time like oh you know so and so doctor sent me in today because they're still waiting for an authorization for my CT scan.

It's been several weeks. In fact, I just had a case a few months ago, and I have to be careful with like obviously patient information, but where a lady came in that had this belly pain forever.

And like she was trying to get a ultrasound approved from her GYN and the insurance kept blocking it and all this stuff. And it was like a delay. Ultimately she came into the emergency room.

We ended up scanning her and she was just like loaded with metastatic, like ovarian or uterine cancer. I forget what it was. And like, it would be hard to connect those dots, but it's not hard to think like, Hey, if this was done six months ago, like, could she have survived this?

Cause she wasn't, I mean, this was already like stage four or stage five, like, It's just, it's scary to think of this stuff out there. And, and is like in someone in healthcare, I can tell my family, Hey, call me if there's something that you have going on, let me know.

Cause I can at least try to quarterback these, you know, situations. But for the average person out there, there's not a whole heck of a lot you can do.

It's people who have never taken care of patients dictating care and indirectly making medical decisions. That's why the joke in that video, the Prioroth video is these insurance companies are practicing medicine without a medical license.

And because these decisions that they make they're not deciding that this person is going to be treated this way, but by withholding payment, by delaying payment, there's no path to getting that recommended treatment done, right?

So it's an indirect effect, but that's still what's happening. And sometimes it does take, you know, comedian ophthalmologists, I guess, to like to make sure people understand that.

Right. And so, um, I don't know, it can, it can feel though, a lot like. like what what's really to come of this stuff, you know, like I'm kind of riling people up with all these health care videos.

But, you know, we've had some legislative wins, you know, a lot of good advocacy work. And a lot of that is, is, you know, kickstarted on social media, because that's where people get their information now.

Yeah. And so it's important. And a lot of people are doing that advocacy work. But so, you know, I always try to remind myself of that. Like, OK, like no one no legislator is going to like introduce a bill because I made a comedy video.

But it's like the accumulation of of just getting more people to understand what the problems are in health care. and then being vocal about it. So if I can tell all my audience, all these people, like, oh, look at this problem.

Look at what a pharmacy benefit manager is and how that is affecting the cost of your care. And then all those people get angry about it and start talking about it.

And all of a sudden it starts to kind of snowball. Right. And so we can't ignore social media, especially like when we have this type of institutional knowledge about the health care system.

Right. We need to, to, to give that to people who don't have that knowledge. Yeah. And I don't really know what the answer is. And I, you know, I think obviously physicians have to continue to try to advocate for their patients.

They need to try to fight the, you know, prior authorizations when patients have needed treatments or needed diagnostics. I think patients need to continue to, you know, get on the horn and yell and go up to the top of whatever supervisor they have.

I know it's kind of a probably feels like you're running uphill on this really steep treadmill at times for patients. I really don't know what the answer is.

I know. Well, I, yeah, I think, well, sorry. No, you're good. I do think that, um, paying attention on a state level at least, which is it's easier to get legislation passed that way.

Ophthalmology, Emergency Medicine, and Closing Thoughts

Especially if you're in healthcare, you know, find out what what's on the agenda, you know, for your state legislature, you know, going through your state medical society, your specialty medical society, whatever that is like they they're plugged in, they know the types of legislation that's being proposed that has an effect on healthcare in your state at least.

And that's where we've had, certain states have had prior authorization reform that way. And Oregon just passed a bill that limits the corporate practice of medicine by preventing private equity firms from being majority owners in medical practices.

Arkansas did first of its kind PBM reform bill law and signed into law and so it like there's incremental change that can happen is not going to be like a wholesale change like that's a pipe right like people that are like.

Healthcare for all like that's great like we could want that all day and I want that I want everybody to have accessible affordable healthcare But but it's it's it's not going to be like we're going to pass something and we're all

going to have that but I mean That's not going to happen, right?

So it's got to be we got to take our wins when we can find them You know the no surprises act You know, there's there's things that that we can actually feasibly do in the short term to make lives life better for patients and for physicians and other health care workers.

Yeah, definitely. For sure. Well, I think I wanted to try to I always try to end the podcast on a positive note. I know there's been a lot of some pretty heavy hitting subjects that we've hit on here.

Any intersection with ophthalmology and emergency medicine that like comes to mind for you? How are your slit lamp skills these days? Not as good as yours, I promise you that.

Does your slit lamp work? We just got a new one and by new, I think we got it from an ophthalmologist's office and it is like at least 25 years old. It's an old, it's an ancient one.

It already looks like a medieval torture. For sure. I can't imagine what a 30-year-old slit lamp probably looks like. One thing I learned is that it's very different practicing ophthalmology out in the community versus in an academic center when you have access to residence.

When I was in residency, big academic center, Iowa, level one trauma center, every single, if it was an eye problem, come on, I was getting a call. I was a resident, right?

That's what we got to see as much as we can in this short period of time. So I get it. That makes sense. I thought it would be the same when I went out into private practice.

Now I'm in a community where we cover three different community hospitals. I am an outside ophthalmologist. You know, I work, I see patients at outside hospital and which, you know, is seems to be the butt of the joke for a lot of people in academics.

But I realized once I got out there that, man, you guys emergency visit. And I'm not just kissing your ass because I want to just to engender myself, you know, some goodwill with your with your audience.

But I mean, it does help. But you really do know what you're doing. You know when to call us. And I think that makes all the difference. You don't have to know what's going on with the eye, but you know something bad is happening, right?

And that's really all we can expect as ophthalmologists for you to be able to do because nobody outside of ophthalmology really knows much about ophthalmology.

We know that. Like, come on, I'm not going to ever ask you what the fundus looks like. That's not fair. I appreciate that. But all of you guys out in the community, at least, you know when you need to call us and when things that you could take care of yourself.

And so I've been really impressed. Well, I appreciate that. The kind words, we don't often hear them from subspecialists. And I think a lot of times people fall guilty to the thought process like, you know, orthopedics and surgery and everything.

Well, just do this or just reduce that fracture. That's your field. I need your input because I'm not an orthopedic surgeon. I do know about orthopedics.

I have to for my job, but it's nice to hear. Don't ever let an ophthalmologist get mad at you for calling them in the middle of the night. Trust me. We've got a nice life.

We've got a nice work-life balance. Come on. I've built this whole social media business just because I work four days a week, which is full time for an ophthalmologist, but still.

I've never met an angry ophthalmologist. Yeah, there you go. Never. There you go. As long as you have a vision. A lot of angry surgeons. Just get the vision.

That's all I ask. Just have some kind of vision assessment. That's it. That's not a lot to ask. Definitely not a lot to ask. Um, so I guess the question becomes now is what are you working on now besides, uh, you know, obviously got the, the comedy gig, you're doing some standup comedy.

Yeah. Yeah, we're, we're doing, um, so my wife and I, we do some, uh, every year we go around the country a little bit, um, depending on how much time we have to do some live shows.

So we have our wife and death show that we, um, we do. Uh, we've got a show in July in Portland and, um, a couple others later this year. Uh, it's a, it's like a theater show.

It's got, cause we've got lights and I'm wearing costumes and stuff. It's, it's really a lot of fun, but it's based on our life story. Cause you know, I've had cancer diagnoses and obviously the cardiac arrest.

So it's a very, um, you know, lots of highs and lows in that show. We also have our podcast knock, knock high with the glaucomflex. Yeah. So I've heard about this.

I gotta check this out. Yeah. Yeah, it's great. So we do, uh, Kristen and I, we do some episodes together and then I do some by myself where I just, I talk a lot about eyeball stuff.

So yeah, emergency physicians may actually learn a thing or two about eyeball. And, and then, I don't know, we always got other things in the works. Still doing the skits, you know, I'm trying to slowly like educate people about everything in medicine.

I'm going through my first aid book, which I have right here. I don't have any like, uh, uh, you know, endorsement for first aid. I just like, I wanted to take just random topics from first aid and make videos about them.

Cause I'm on this kick of like, yeah, I can, I can tell jokes like about ortho all day and it's great. You know, everybody loves making fun of ortho. Everybody loves ortho bro.

But I'm trying to explore how far I can push the education in comedy. Is it possible to make lysosomal storage diseases funny? That's one of those, the holy grail of medical comedy.

So anyway, that's what I've been experimenting with lately, and I'm really enjoying that, seeing if I can trick people into learning things that the otherwise wouldn't normally learn.

That's funny. I did notice that on your videos. Like you have this pivot to like just like a random educational topic today. And I'm like, I can't wait to see how he somehow incorporates humor into the Krebs cycle.

Like that's what I will have been doing. I've been doing the New England Journal of Medicine. You know, I have a, a, a, a relationship with them where I am.

They've given me, they give me some, uh, it's one of my, the word I'm sponsorship, like a brand promotion sponsor. Right. Right. where they give me some of their trials.

And then a couple of times a month, I make videos about their trials. So it's like a video comedy abstract. That's incredible. Which is the thing I made up.

I didn't even know that was a thing. I was going to say, I didn't even know that was a thing. I don't know. I'm not sure if it really is a thing, but for now it is.

So anyway, it's been fun. Well, good. Well, God bless you. I'm glad that, you know, things are going well for you, and I'm glad that you took the time today out of your busy schedule to say hello with Emergency Minute and some

of our listeners.

So you definitely have a superpower, your ability to toe the line in some of these, you know, like we talked about, just being able to sort of be able to make fun of people without being condescending and actually quite humorous is definitely your superpower.

You are the Michael Jordan of doing that, no doubt about it. I appreciate that. But yeah, as I conclude all of my shows, I try to say something very positive that I learned in residency that I say to a lot of my patients.

I say peace, love and happiness to everyone out there. Cheers.