Ep65 | The "Invisible Hand" Series - The Effect of Medical Malpractice on Health Care with Dr. St... Transcript

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Conflict in Healthcare and the Spark Framework

If you work in healthcare, [music] you already know this. Conflict is everywhere. In the O, [music] in labor and delivery, in committee meetings, between physicians, nurses, administrators, and teams that are all trying to do the right thing. But here's [music] the problem. Most of us were never trained to handle conflict well. We learned procedures. We learned diagnostics. [music] But we didn't learn how to navigate the moment when Q professionals strongly disagree.

That's why I developed the [music] Spark Framework. Spark stands for stop, pause, ask, don't assume, reflect, and respond, and create a path forward. It's a practical system [music] designed specifically for high stakes healthc care environments through keynote talks, residency workshops, and spark master classes. I teach physicians, nurses, and healthcare teams how to [music] turn destructive conflict into productive conversations that strengthen teams and improve care.

Tax Strategy Sponsor Message

If your hospital, residency program, or medical conference is [music] looking for a speaker on conflict, communication, and leadership, and healthcare, [music] I'd love to work with you. You can learn more in the show notes because in medicine, conflict is inevitable, but [music] handled well, it can make teams stronger.

Quick question. Are you paying more in taxes than you should? Most high earning physicians [music] overpay by tens of thousands because their CPA only looks backward, not forward. Guilt is different. Dedicated CPAs powered by AI that work year round, not [music] just at filing time. Tax strategy and proactive planning for practice owners, investors, [music] and physicians with complex financial lives. Built specifically for professionals who want to keep more of what they [music] earn.

Introducing Part Two with Dr. Steven Cohen

Check out joingelt.com. That's j o i n [music] gt.com. Welcome back to the scalpel and sword. Before we begin part two of my conversation with Dr. Steven Cohen, I want to make one recommendation.

This episode is designed as the conclusion of a threepart journey. If you haven't yet listened to episode 51, the invisible hands on the scalpel, and then part one of my conversation with Dr. Steven Cohen, I encourage you to start there first. Episode 51 introduces the concept of the invisible forces that shape every decision we make as physicians. Part one explores how the world of medical malpractice influences surgical judgment, learning, and professional identity. In today's episode, we take the conversation even deeper. If you've made it this far, thank you for joining us on this journey. Now, here's part two of my conversation with Dr. Steven Cohen.

Trust but Verify in Clinical Decision-Making

[music] In every operating room, in every ward, in every clinic and every team meeting, a silent battle bruise, conflict, negotiation, identity. Welcome to the Scalpel and Sword podcast, where I, Dr. Lee Chararma, [music] physician and conflict analyst, explore the hidden negotiations beyond modern medicine. Let's trade burnout for boundaries and learn the art of healing with precision [music] and power.

There's something really important in this concept and this conversation with how medical malpractice has shaped medicine is one of the things you're talking about is this concept of very profound directed accountability with the surgeon or with the clinician that's prescribing the medication or the surgeon doing the procedure that if your thought process well so and so told me this is what it was so and so said this is and the thing is that it's still your

decision And it's still your intervention. You're still the one who's talking about the patient. You had a really interesting post on LinkedIn. I think it was two or three weeks ago that got a lot of attention. And you probably know that I'm going to mention about a surgeon who was sued because he did a surgery based on a radiology read and the radiologist got on the stand and said, "Yeah, I made a mistake." >> Yeah.

>> I didn't read that correctly. And the radiologist was not named in the suit. I mean, the radiologist was being as transparent as that person, I'm sure, knew how to be, but ultimately it still has resulted in a lawsuit for the surgeon who made a decision based on that. So, I think one of the things that medical malpractice has done for us as clinicians is it has created the idea that there's lots of data out there and yes, you're going to get data that's not correct, but that's still your responsibility to confirm that data if you're making a decision based on that. Is that an accurate way of looking at how it's changed us? >> Yeah. And this is one of the things that I teach every day. It's trust but verify. I don't trust anybody, right?

And we're in a very big facility. Everybody's running around. We're on the second floor. Radiology is in the basement all the way in the back. But I tell the residents, and I I do this in private practice, when you get a fill, we teach to look at the X-rays because that because we're in a teaching facility, but it's not standard of care for the surgeon or any provider to look at the films themselves. You can rely on the experts. However, if there's discrepancy for what you're seeing clinically because the radiologist is not examining the patient, doesn't know the lab work, doesn't know the clinical history other than abdominal pain or some one line we write on the forks, go down and talk to them because a lot of times I've gone down and talk to them and say, "Look, here's the story." Go, oh, well, yeah, you could be right.

Okay. So, they may change what they see being directed based on the clinical history. And that is so important to not just rely on what they say. A lot of times it's not to pick on the radiologist, but we have a lot of night talk, right? Radiology is now remote. They're sitting at home somewhere in the country. Every film that's read at night has to be reread in the morning, but in the morning you six or eight hours has gone by. You may have a patient that was not so septic and survivable. 6 8 hours later now it's not survivable. So, it's really important. You could trust that, but you got to verify it. The gastronurologist, the radiologist, everybody, because you're the one that's making the decision. And the other thing that's important, especially in medical malpractice, is don't throw your colleagues under the bus. That drives me crazy. You can have a conversation offline, but don't write in the chart, I told them this, they were wrong. Everyone's going to write the check for that. That's not defensible. And I see that a lot unfortunately. And that case really hurt me. So I was on the defense side. That case went to trial.

>> Yeah. >> And again, the radiology happened at midnight. Abdominal pain. Everything was normal. Patient ate Mexican food. Had abdominal pain. Got better in the emergency room. There's a questionable reading. Patient was told to follow up the next day. They didn't. Three days later, dead bowel. Right.

Teaching Residents to Use Clinical Context

And then four years later, the radiologist said, "He made a mistake. You're going to hold me accountable for somebody who overeats four years later, right? So, that was a tough one.

>> I love that you teach looking at radiology. I do film rounds. I always do film rounds. It's like I get a report radiologist. Oh, they're seeing this.

They're seeing this pelvic mass, this in the uterus. Well, let me go look and see what you're seeing. I want to go see what show me this. It's like, oh, I'm not sure that that was really an accurate measurement on the endometrium.

Cool. What is the accurate measurement? Cool. Can you update the report? Thank you so much. Because that is the difference between me possibly operating on a patient possibly not operating on a patient%.

They talk about houndsfield units which is the density of the fluid. Sometimes they don't measure it and I want to know if that's blood or mus that makes a difference. Is it free fluid? Is it not? So you go down and look at what is the house field. Oh yeah that's uh you know 65 that could be blood. All right the hemoglobin's hey let's operate. So that

may make a difference and it's not their fault, right? It's not their fault. They have a lot of films. They're in a dark row. What's the best way to hide a $10 bill from a radiologist? Attach it to the patient. And I'm not picking on them. They don't see the patient. It's not fair. It's not fair because they can help guide you make your clinical decision, but you got to make the clinical decision. You know the patient.

You've done the abdominal exam. You know the laboratory work. They don't know that, right? So, that's really, really important. You put that in context for them, all of a sudden it may change your diagnosis, change what you do. A lot of times it comes up with bowel obstructions, high grade, partial, is an ilas. If you're think it's a high-grade obstruction, I'm going to operate on you, right? And sometimes it's hard for them to tell. Well, if they know they've had four days of an NG tube that's putting out three liters a day, >> Yeah. >> but their radiology report says, "I can't tell." You just made the decision, right? If you can't tell based on clinical operate, right? I'm going to prevent the perforation. I'm going to prevent the dead bowel. So, putting it in clinical context is really important.

And I can't emphasize that enough to the surgery residents. And I know they're running around. I know they're busy. We're all busy. I get that. But you're the one that admitted the patient. You're managing the patient. And you don't want to miss anything. And helping them put the clinical context will help you make a better decision. >> 110%. And I absolutely agree with you that this is something that we do have to not only teach but we have to exhibit, we have to do it as well as talking about it. I got called in a consult a month ago from an intern and said, "Hey, I've got a patient that they say has a tubarian abscess." And I was like, "Okay, tell me the story." It's like, "Well, she had an appendecttomy about 3 weeks ago and then she got readmitted and they're saying that they're seeing a fluid collection the right lower quadrant." I'm like, >> "Okay, that sounds like an absence." Yeah, that doesn't sound like a TOA. But I tell you what, I'll be happy to see the patient in the morning. And so the first thing I do is I go look at the films. And it's like, hey, hey, can you people at the film's like saying, you know, she had nappy three weeks ago? What?

>> She had nappy three weeks ago. >> Oh, that's not a TOA probably absess. Cool. Can you update the report? Sure. Thanks. And then I message the intern.

It's like, hey, give me a call. And he calls me. He's like, so I did regular fields with the radiologist. And you know what the intern said to me?

Training, Work Hours, and Surgical Mentorship

>> That's a really good idea. And my husband says that my face was just and it's like to her that's a really good idea. You should definitely get in the habit of doing that. So my only hope is that behavior being modeled for him. Hopefully we'll think about that next.

>> But we have to do the thing if we want the learners to do the thing. >> Well, what's the most important thing that me and you were taught as a medical student? 80% of the time based on the history of what you tell me, I should be able to come up with a really good differential diagnosis. You tell me you had epidectomy three weeks ago and you have an absence. I already know what that is. That's not it. Right. So, right. History is so important. I tell the medical students, go back after the residence round. Go talk to the patient yourself. Get a history. We did that a lot in medical school. I had my own patients as a medical student. I'd sit there and take the history, present to the technique, try to come up with a differential. I was not right the first few. I didn't know what I was doing. And that's fine. But I learned about that.

So there needs to definitely be more of that even at the medical student level. We have third and fourth year medical students and I love at that level and I tell the medical students I always ask what they want to go into. For some reason they think that I wanted them to say surgery and that's exactly the opposite. I don't want them to say surgery and they look at me like I have three heads. Why? When you're a medical student of a surgery rotation, that's the only time you're going to get surgery. You need to know pre-operative indications why we operate but more importantly when to call us right on a case right now patient came in with a large bowel obstruction 5 days no NG tube laxatives enemas nothing was working perforated wound up with a total callectomy never called surgery until she was in septic shock why right if you're going to do surgery I'm going to get you for five plus years and I'll smack you around and teach you that stuff. But yeah, >> as a medical student, when are you calling us? Right? I

mean, that's going to be a problem for the internal medicine doctors. They didn't call anybody. Make it somebody else's problem. If they don't get better with the routine things that you're doing, call someone.

>> And that's really important. So, I love the medical students that are not going into surgery because that's the only time they get it. And at least in our program, they shorten the amount of time they run surgery, which also drives me crazy. When I did surgery 30 plus years ago, three months. Three months of surgery, three weeks of medicine, the pediatrics, it's two months and four of those weeks are sub specialty. So you may do four weeks of general surgery, that's it. Two weeks of plastics, two weeks of ortho, and now you're in practice as an internal medicine. You need to know when to call us.

>> And I think that's something that people don't realize the value of the third year. People think the value of the third year is choosing a specialty. I love how you phrase that. The value of the third year is to get to actually immerse yourself in a topic that you would never actually specialize in. And that is how you build relationships and understand this is what I want to call you and it's okay to call you for these things. This is what I'm learning how to do. >> Right.

>> One of the things that you also talked about in our note was the idea that medical malpractice has sort of driven this population of high volume specialists and subsp specialists. So people who do a lot of X procedure but they do it really well and the concept of you know because maybe somebody who does that procedure 20 times a year is not going to be the same with somebody who does it 100 times a year. So is that something MedM has really set into?

>> Yeah, there's no doubt because I'm board certified in general and colurectal surgery. I get asked to review a lot of cases from a general surgeon that maybe does three or four hemorrhctomies a year. I used to do three or four a week, right? So, they're looking for a specialist to say, did that provider met the standard of care? But standard of care is the same. I mean, certainly the routine things that I'm asked to look at, hemorrhoid surgery, callectomies, bowel obstruction, that's taught in the surgery level. You don't need to be a specialist to be able to appline or to do the right thing. So, it surgery has driven I think more malpractice. I think it's important for general surgeons. If you're not comfortable doing something, don't do it. But again, you're being pushed by everybody above you to do more cases, see more patients, and that's a problem. We have a very good general surgeon now that works with us that he won't do any of the analctyl stuff. He doesn't like it, but that's one thing.

But he sends to the colarctal department all the things that he doesn't feel comfortable doing because he knows we do more of them. But I definitely think the more specialist you are, if you're not used to doing those certain procedures, it can be a problem. >> So there is something in that that sort of driving this to the more the high volume specialists. And I think also too, you know, and you talked about this that if you're supposed to be meeting a certain benchmark with procedures and things like that, it makes it really difficult to be able to pass those off. I think that also goes handinhand with employed versus independent doctors because as you were talking about that I'm an independent clinician. So I have no problem saying, you know, oh, this definitely needs to go to general. I do not need to be touching this. I have no problem doing that. But it's easier for me to do because I'm not trying to meet somebody else's benchmark. And I fully completely see that. I really do love how you teach your residents.

Documentation, Family Communication, and Empathy

I love how you really are preparing them to be real world because work hour restrictions is something you also mentioned in ours in terms of sort of this relationship between work hour restrictions, maybe the residents not getting as much hours, but how that also plays into the male practice environment with regards to fatigue and things like that. You've educated surgeons for a long period of time. So, you've gotten to see what education look like before work restrictions and after. How do you see that affected training and how did that play into malpractice in your vision?

>> Yeah. So, I've been looking at a lot of cases recently where there was a bad outcome, not malpractice, but on the plaintiff's side, they wanted to emphasize that it was a new user, right? And he'd only been in practice for a year and he should know better. He should have called somebody else to help him. But this is surgery 101, right? So certainly I don't put anybody at a higher level or I don't look at it different whether you're one year in practice or 10

years of practice. Most common bile duct injuries are surgeons that have done hundreds of gallbladders. Right? So it's not usually the new surgeon. Most new surgeons as we're teaching in training know when to back out. They don't feel comfortable doing it. I think the other thing that's changed is that most people going to practice now were not like me 30 plus years ago where I went into a private practice and joined other people on the group. Most physicians are now employed >> and when I've talked to a lot of the chief residents, what are you looking for? What kind of practice do you want?

They want to be mentored. Well, I never thought that. I felt when I finished my seven years in training, I could go out and do everything, right? But it's a little bit different. I think that 80 hour work week is they don't get the same volume of surgery. They don't see the progression of their patient, right?

You know, we were I don't know better or not, but we were inhouse every third night for five years. That's just the way it was. I didn't know any better. I knew what I was signing up for. But now, obviously, they don't take a lot of in-house call. They have a night flow system, meaning there's physicians in training that just cover the nighttime. you don't really know the patient, right? So, I think all of that is compounded and has made a problem. A lot of cases I review, believe it or not, as you can figure, nights, weekends, holidays, and it's not your patient. It's the partner's patient. They didn't do the surgery. There's no documentation that there was a couple of cerosal tears that they may be concerned about. So, when they got a little septic, they weren't thinking, I need to go back to the operating room. It's little things like that. And I definitely think the training has changed and we just need to emphasize that we talk about cases and we did this in our private practice. If you're rounding on my patient on Saturday and there's a problem, just take care of the patient. Don't put it off to Monday because what happens? The patient's now septic and there's a problem, right? I think the training is definitely changed that they're not used to following the patient every day, being in the hospital all hours of the night, watching the patients clinically change. we can't anticipate everything that's going to happen and they've lost that. So I think that's why a lot of them feel they want to be mentored, they want to join a group, they want to have a senior partner help them on their big cases for the first few years and that's okay. But I definitely think it's changed over time. Yeah, I agree with you and I think the quality of life that people are looking for and this is why we're seeing surgicalists, you know, hospitalist, laborist, we're seeing this model take over everywhere. And there's good to that model and that I think there are people who are looking for quality of life. But the flip side of that is it does by necessity have to change how we practice. We have to be more communicative. If you are signing out to somebody, if someone's covering your patient on the weekend, hey, just so you know, I did this patient's case on Monday. This happened, this happened, and I think she's fine, but if she calls, so you know, I'd be really, really quick to do something with this. That's an easy thing. It took 10 seconds, but that level of communication is something that has to improve if we're going to change the model and how we follow these patients. So you were talking about the importance of documentation and how we write these things down and how we express ourselves. How do we tell the clinical story of this patient? There is a quote that you have and I love this because I think it follows with this. surgeons now operate in parallel with a legal narrative. And I love that because I think if there was one thing people were listening to this podcast that they want to take with them, it is the idea that how we document the story we tell, the way we intervene surgically with patient, we are doing this in lock step with a legal story that we are also telling and we have to be aware of it. >> Yeah. And that's really a good point.

And the other thing I try to emphasize to the residents and when they look at it through this lens, it clicks for many of them. Pretend like that's your mother or your father. How do you want to take care of them? Right? My parents have been patients in the hospital, you know, and I did tell them what I did for a living and my father's a retired surgeon. But some of the treatment you get when you see it from the patient side, it's amazing and it's scary sometimes, >> right? So pretend like it's your mother.

Pretend like it's your father. What would you want for them? Right? The nurse calls you. They want something right away. Don't wait 15, 20 minutes. I know you're busy. Get somebody else to cover. Get somebody else to answer the call. You have to be available for the patient. If you pretend like it's a relative, you're going to treat them a little bit different. And remember, most drivers of lawsuits is not the patient. It is not the patient. In my first lawsuit, it was a wire that was left by anesthesia during my surgery. We didn't find it till three months later. She called it with abdominal pain. We took the wire out. She was fine. They forgot to name the anesthesiologist who put the catheter in. They named me, but I didn't put the line in. She called the office 6 months later wanting to make an appointment with me. My office manager said, "You can't see Dr. Cohen. You're suing Dr. Cohen." She said, "I'm not suing Dr.

Cohen and I love Dr. Cohen.

Malpractice, Expert Witness Work, and System Change

" So most drivers in law suit is not the patient. Getting the family involved is very important that they're not always around. I get that. But that's also important to tell them what else is going on. You don't have to talk to 10 people. Somebody in the family what's going on, what the plan is, what you're anticipating, what you're doing, what you're not doing. That's really important too because the driver sometimes the family members, the relatives, >> somebody else.

>> Absolutely. That is one of the things that sometimes I think we're afraid to sort of reach out in that way. I think sometimes that's scary for us. And one of the things I hope that people can learn as they listen to this podcast, I think so many people in our industry as physicians who are really actively teaching skills with communication and empathy. This is the reason why you got to learn that kind of stuff. It does a long way in preventing this kind of problem that if the patient and the family both feel like you're invested in their process of healing, they are going to see the caring. And as you said, the outcome doesn't speak to the quality of the care. But also too, in the same way, communication can go a long way if there's a bad outcome.

>> I tell the residents and medical students, it's easy to be a doctor when everything is going right. But when you have the complication, when you had the difficult patient, when they want to leave AMA, then you put on your big boy and big girl pants and you want to be a doctor. I remember when I was an intern, first day in the ICU at Boston City Hospital.

>> They said, "Who's the new intern?" Me, Steven Cohen, we just declared this patient braid dead. Go into the family room and tell the family we're pulling the plug. This was an 18-year-old motor vehicle accident. So, I'm thinking to myself, I'd never done that before. Are you kidding me?

>> That's what I was thinking. I told the chief I'll take care of it. Right. Right. I go into the waiting room and I have to tell 30 people that are already crying that we just pulled the plug. >> You can't teach it.

>> Right. Where did I learn that in medical school? Did anybody teach me that? Right. But yeah, >> I'm walking to the waiting room. I'm telling myself, you wanted to be a doctor. Put on your big boy pants. This is what it's like. So, it's easy. It was going right. I can't put every resident and medical student in a tough situation, but that's how you learn, right? You have to be compassionate. You have to be empathetic and it's tough.

That's the hardest part of being a doctor when you have the difficult patient, but that's what you have to learn as you go along. >> So well said and 100%. [clears throat] So, as you look at medical malpractice just as an institution and the effect that it's had on the United States medical system, do you see that being a continuing influence? And if yes, is it a positive or a negative one globally? Is there any way to actually make that determination? >> Well, I think it's a negative influence definitely. I mean I think you know before podcast before the internet for all this and nobody talked about it right I think the work that Gita is doing because I've been on her podcast as well she's actually coming to VCU to give the grand rounds that I usually do every year because I wanted to hear her talk and I want the residents to hear it talk rather than they hear me talk all the time I think they're tired of me at this point but I think these conversations are very important the more that we talk about it and you learn the system and you learn that you're not a bad doctor you're not the one that's causing the problem if you're doing everything right. If you're documenting, you're talking to the patient, you're getting collaboration from the family, you're doing all the steps that need to be done, I think it's going to become positive, and we're not going to be so fearful about it because right now it's fear of the unknown. And I've had residents that have left our program that have called me as soon as they got served say, "I need help. You know, what am I doing?" And we've had the conversation. But when you're emotionally involved, it's a whole different ball game.

>> Absolutely. And I love how you're encouraging them. I think the acceptance that we're afraid of the process, but even being afraid. There are things that proactively we can do to actually take part in the system in such a way that maybe we're not just helping ourselves not be as fearful, but we can also improve the practice of medicine. That there is a way for us to put our hand back on that scalpel that actually can improve healthcare. And you're definitely

doing it, Stephen. I mean, you're doing it as an educator, but you're also doing it as an expert witness. And I also I want to say this to you that being an expert for the plaintiff, you've stopped more cases probably than you've testified for. >> Again, like I said before, I get a lot of grief. Why do you talk to a plaintiff attorney? There's a 40 to 50% of the time they're not cases and the case goes away. And I explain it to the attorney.

Sometimes they don't want to hear it. The good attorneys, the plaintiff attorney is not going to take a case if they don't think that's a win. And a lot of times I tell the plaintiff attorney, I wish you were the defense attorney because I could defend this care. This is exactly >> the standard of care. It's how I take care of patients. This is a big and they want to hear that. And the other thing I've done, probably one of the few that ever does it, I tell the plaintiff attorney, I'm happy to talk to the patient or the family and I'm not emotionally involved. I can say this is what happened. And a lot of times when I've done that, it's very interesting to talk to the family because I ask them you know what if it's a death case it's different but patient has a bad outcome they went with a colostomy what's the worst thing that happened and then family starts complaining about the nurses didn't pay attention it took them five minutes to answer the call your colostomy bag broke you know it the way they look at it we look at it different than they do >> so I will tell you that having been a patient having family members that are patient. You understand that? And I think I don't want doctors to become patients, but eventually we all are, right? We all have the same things, right? When you look at it from the patients perspective, you treat them a little bit different.

>> That is amazing. And I love that you do that. I really kind of look at that work, the things that you're doing when you actually are saying that you'll talk to a patient's family, you'll talk to a patient as the person who was contacted by the plaintiff. That may be the future of what we need to look at in the medical malpractice system. Nothing gets dirties. My daughter is one. But the idea that part of how we also put our hand back on the scalpel is we're willing to engage more and create a process by which the patient the patient's family can have a deeper understanding of the medicine on some level as we do. And I think that's just one more way we can build that connection. We want to build that relationship of trust back in with our patient. This is another way we can do it.

>> Oh, I 100% agree. And it's been great. Great. I mean, I like talking to the family members. Again, I've been yelled at by the family, I don't know what you're talking about, and this and that, but it's easier for me to explain the medicine when I take the emotionality out of it, right? And the attorneys don't know the medicine. So, they're trying to explain a complicated thing and, you know, I make it as simple as possible, but the whole system is difficult. Think about it from a jury standpoint. They have a fifth or sixth or eighth grade education at the most. It's not their fault. It's just the cool of people. They're looking at two boardcertified, qualified experts trained the same way, been in practice just as long saying exactly the opposite. How are they supposed to figure that out?

>> Right. So, it's difficult. I think the system should change, >> but it's not up to me. But for now, I think the things that you're doing that we're doing to try to educate everybody, defense attorneys, plaintiff attorneys, residents, we can make it better in the future.

>> 100%. Stephen, thank you so much for being here. I knew this was going to be a fantastic conversation. It exceeded all expectations. If people want to reach out to you if they have questions about your work, how best would they do that? >> Probably the best way is through LinkedIn. I'm active on LinkedIn. I like to talk a lot. Let's see. Yeah, my email was on there. Cell phone was out there. Happy to talk to anybody about any issues, but that's the best way to get me.

>> Fantastic. and we will put that in the show notes. To all of our peaceful warriors who joined us today on the scalpel and sword, if this episode resonated with you, please share it with a colleague or a friend. And until next time, be at peace. Every [music] episode is an invitation to speak, to negotiate, to choose. I'm Dr. [music] Lee Chararma. Join the dialogue by subscribing to Scalpel and [music] Sword. Until next time, peaceful warriors. May your choices be sharp and your voice be even sharper.

[music] This podcast is a reflection of lived experience and [music] research in conflict resolution. The scalpel and sword is not intended as medical [music] or legal guidance. For personal matters, please consult a qualified professional.