Reclaiming Joy and Agency in Medicine with Dr. Nanette Nuessle Transcript

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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 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 Nestle. Dr Nestles 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. And Nan's a fascinating person. I think you're going to find this conversation interesting and I appreciate you being here.

So Nan, would you mind introducing yourself to our audience? Thank you, I'm Nanette Nestle. I am 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 pediatrican and ended up going through a fellowship in medical genetics and then wanted to be in private practice.

I didn't want to in academia. So I found a place where I was able to do both. And I hired, or so I 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's very long.

When I left there, we didn't. Yeah, when I lived there we have 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 want to make any money And we don't bring money into the clinic.

Pediatricians in general don' bring a lot of money to a large clinic like that compared to, say, orthopedic surgeons. And this was back in the 1990s.

Early Career in Pediatrics and Medical Genetics

The top earner in a clinic made over $6 million a year. Goodness. Our pediatricians were making about $120 million. So a huge spread. Cue spread. Yeah.

Primary chair, we didn't have anyone in primary chair making over 250,000. And we did have any subspecialists making less than half a million. So there was a real big divide in it.

It was problem. But I managed to work my way up to chair one of the department, both at the clinic and at a 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, you know, 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 because that was the day I was doing genetics.

So I always working the same number of hours in practice that I working as a resident. I'm 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 miss my son's 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' 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 They don't, you're not working a hundred 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, so I was really happy with it and I didn'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 again. I think being unhappy, being frustrated, and being bored with what I was doing.

Whereas when you're in the hospital, you have no idea what's coming in your 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. And that's what drove my happiness and my pleasure in medicine. It's the one I found that I could do just that.

I was much more satisfied. which were 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.

Burnout, Bullying, and Leaving Outpatient Practice

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 always burned in a fire when it 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 and reconstructive surgery three times a year from the time I would six or seven until I wasn't in my twenties. Wow.

I chose medicine as a way of paying back the surgeons and the nurses who took care of me when I'm 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 mean, horrendously bullied at school. Even some of the teachers bullied me. At the hospital, that's the only place where was accepted for who I am.

No judgment. And so that's what I thought medicine would be. When I got into medical school, I found it's not that at all. 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 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 is giving a lot of us imposter syndrome. 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 were women, docks who had some sort of birth defect

or scarring, doc who spoke with an accent that was different.

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. I wasn't eager to go. 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 will contradict me in front of patients or after I finish running, She would going 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 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.

Finding Fulfillment as a Pediatric Hospitalist

And all of a sudden, she didn't know how to respond. She didn' know know to pick apart anything I did because I was agreeing with her basic values and communicating with it 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, to stealing with dischargers. Almost everyone was on antidepressants or anti-anxiety meds.

Thing, 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. Well, it's just interesting how much like all the way through like what we learn.

I mean, you've noticed this when you're taking jobs or when your 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 to practice.

But the personality and the ways 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 helped to manage some of those things because dealing with, I always tell people, Learning stuff is hard, but totally doable.

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

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. Nurses are other personality types. 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.

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 woman of this has had trauma since going into.

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 middle of the night because they don't know you as their physician.

You're just the doctor on call and all these things.

Childhood Trauma and Medicine as a Safe Place

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 the emotional charge to dealing with both of those.

If you've practiced to write either of those, you get trauma from them. And so I've added trauma coaching to what I do. What I have 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, you're able to say, oh, yeah, I feel a little bit triggered, but I'm acknowledging that and I moving on and not gonna let it affect.

how I deal with this other staff member. I'm not going to throw things, I am not gonna raise my voice, and just acknowledge that, yeah, that's what I feel, but I can choose to respond in a manner that is going move things forward and be better for the patient, better me and better the team.

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

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, more, I realized that how you do stuff matters almost just as much, if not more than the outcome. Because you can get an outcome, 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 to a surgeon, Yeah. 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 they said well you know that that is 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. Interestingly, this lady did go see another surgeon who recommended the identical procedure and probably had 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 is 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 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. For me, I had a lot more terrible 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 chart done.

I have days were 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 always 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 has been an issue for my entire career and I've been doing this almost 40 years.

Parents coming in and becoming very confrontational when you bring up the subject of vaccines. 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.

Bullying in Healthcare and the Power of Coaching

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.

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.

That just got to be very taxing for me. When I transitioned into being a Pete's 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, And I was much happier doing that. And here's the thing, Peds 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. When I talk to younger physicians, I tell them, 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 are able to do that.

Well, I think it's interesting to reflect on all this stuff. And it is also interesting, Nan, just thinking about you and expertise and interests. Not everybody would rather run codes and deal with toxic, ill children.

I like a lot of people would think like, well, that's the hardest part of my job. But, You loved what? Yeah, you liked helping people in those settings.

You were able to make this huge difference and help people at 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, They 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 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 oxytoxin dopamine seratonin 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 your in-stress, there are certain things you can do that will raise these other three neurotranmiters.

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

Have a time when you go out for pizza together or Chinese.

Trauma Coaching, Neurotransmitters, and Team Culture

Even the times when we all do a potluck and bring things in, all of that is positive social interaction and it's going to raise those positive neurotransmitters so that you feel better about being there and you'll feel about better being with those people.

And that can break down the barriers in communication. No, that'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, if you've already eaten and it's time for a snack, are you feeling that because you need dopamine or because your need nutrition?

And because that is a way to achieve dopamine. But I also tell people the 10-minute rule, take a drink of water. Wait 10 minutes, do something else and come back and say, oh, 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, 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.

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 it'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 you patience.

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

Well, that's a good idea. I wanted to backtrack for just a minute on something you said. Sure. 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. 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 your 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. Where do you see medicine going in the future?

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

Well, 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 seen in a future, and we're already seeing this in rural areas, is that your primary care physician will not be a physician. You will be primary provider.

There will 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, 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 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, and I'm doing a provider to provider consult, they get bent out of shape.

they have their prejudices. So the hurdles we're going to find are where are our primary care providers going come from and how are we as physicians going interact with them.

I think that you're describing the reality of what appears to be happening.

The Future of Medicine and Primary Care

And like you say, a lot of hospitals, in a of the corporate side of medicine, which has to answer, you know, understandably has the answer for the bottom line and be able to pay the salaries of, of a physician or the nurse practitioner or PA, but they also have to the salary of your, the staff and the nurses and receptionists 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, 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.

And yeah, it has its pitfalls, what every system does. But what you don' 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 the system that does get rid of that pay gap. There is so much prejudice against it in the US that I don't see it happening.

I would love to, but I do not see happening it. There are so many ideas 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 am 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. But I've kind of had some sympathy because a lot of times we've had people that come, And they will come with just right after training.

And I see like, wow, you have had, maybe 400, 600 hours worth of formal training and most physicians have, a minimum of somewhere 12,000 to 15,00 hours' worth, of training, and it's just a tremendous difference.

So you take a really nice, intelligent person who goes through that training 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 hung me out to dry in this little community.

And I can call somebody, but it is not the same as working in a team where you're in the office and you are collaborating with your team of experience.

physicians and people, because 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. And man, it is something like that all the time. I agree. As we talk about this next generation of physicians, I want to get real personal here.

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 felt she really enjoyed the pediatric anesthetics.

And so she has found her niche. Her younger sister, I'm just not sure about. she hasn't go get her personality and she's very dedicated to things. But She thinks that as 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 is not going to be happy with the hours, that's she not gonna be with reimbursement.

But what I do see that's different for these groups, 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.

Career Advice for the Next Generation

When they finally, 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 stresses of the job, and a bigger knowledge of where their boundaries are in terms of pushing themselves physically.

And I think that, nope. Yeah. 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 hoped that we incentivize people to become the kind 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 am 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, need more doctors and more people that have had that broad base of training.

Then we just 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 no fun at all.

Yeah, well, you're right. Well, Nan, tell us a little bit, as we kind of wrap up here, what comes next for Nan Nestle? I always get your name wrong, I'm so sorry.

Nan Nessel, 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.

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. 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, and plastic surgery patients come to the villa for the first few days after surgery to recuperate while the swelling's 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 on my clients.

But the opportunity to live at a villa where they make their own wine in their arm of oil and kick back and relax and only work, say, 40 hours a week, that is very appealing to me.

Yeah. Well, only a doctor would say that. Think about coming back to only 40-hours-a-week. I dream of that day. It's funny but true.

Retirement Plans and Wellness Coaching

Oh my goodness. I don't know what I'd do with myself if I just stopped working. You can just decrescendo a little bit. Well, Nan, thank you for sharing your journey, your perspective, and 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 things can I do to make it a bit more better for those who come behind?

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 your feeling overwhelmed, If you are 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. Bye. Thanks for tuning into the Doctors Making a Difference podcast. And thank for what you do to help your patients and your community.

Your work truly helps so many people. We produce this content to have the tools you need to stay in medicine and to highlight the amazing work being done by physicians around the world.

Closing Remarks and Podcast Outro

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See you next time.