# Taming Burnout, Reclaiming Values: An EM Physician's Journey Transcript

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## Episode Introduction and Guest Overview

Welcome to a special Heartline Echoes episode where we revisit some of the most impactful conversations from Heartline changemaking in healthcare. This rerun isn't just a replay.

It's an opportunity to reflect, reconnect, and reignite the ideas that continue to shape the future of healthcare. Whether you're hearing this for the first time or returning for some fresh insights, let's dive back into this powerful discussion.

Enjoy! Welcome to Heartline, Changemaking in Healthcare. I'm your host, Dr. Andrea Austin, a board-certified emergency physician, physician development coach, and educator.

After years on the front lines, I've learned that real change in healthcare starts within. Each episode invites you to explore the inner work that unlocks clarity and bold leadership, because healing systems through changemaking begins with following our heartlines.

I am so excited today to have my friend and colleague, Dr. Amanda River. She is an emergency medicine physician that's currently credentialing to work at a critical care access hospital in rural Iowa.

She also does locums work in a community hospital in Oregon, and also has worked at a public hospital in Guam. She's a previous owner and medical director of a private cannabis medicine clinic, which I believe this is our first physician that's worked in the cannabis business on the podcast.

So that's pretty cool. And she's also board certified in lifestyle medicine and looking at integrating that into her overall practice as well. So Amanda River, let me start off by saying, You now go by River, which is hard for me sometimes, and I'll probably make a few mistakes during the podcast.

It's great to have you on the podcast. It's great to be on. Thanks for having me. I'm looking forward to getting to chat. So I've had the benefit of knowing you for many years.

We first became friends in medical school, and I always think of you as somebody with a really big heart, varied interests, and endlessly curious. In a way, I kind of find medical school an interesting choice for somebody like you, because when you reflect back on medical school, or at least when I reflect back on it, it's in some ways very narrowing.

You know, in order to learn all that we have to know as doctors, you really have to forego other interests, other things, and go down this extremely narrow pathway of learning everything you can about the human body.

and was for good reason. I mean, humans are complicated and having someone's lives in our hands, we really do need to be proficient in everything that we do as doctors.

So how did you decide to go to medical school? You make an interesting observation that I don't know that I've ever heard anybody actually put into words, but probably one I've had subconsciously myself.

I don't know that medicine was exactly the fit for me.

## Why Medicine and Medical School Felt Narrowing

I kind of fell into it a little bit. It was funny. I found my fifth grade graduation form the other day and on it said I wanted to be a part-time artist and a part-time veterinarian.

And I think that's truthfully probably more where my actual ethos is at. I kind of stumbled into it. So when I was 14 and my sister was 10, she was diagnosed with Ewing sarcoma.

And we spent a good part of a year, my family and I driving back and forth to the university hospital that was about 75 minutes away. And so my parents were both working two jobs at the time.

And so I learned how to drive on the interstates in Iowa and spent a whole lot of time in the hospital with my sister and kind of taking care of a lot of family stuff during that time.

And I remember just being in awe of how We didn't know what was going to happen with my sister. This was something we didn't really know anything about.

And her doctors were, I felt like very honest and very caring. And I thought it was just the neatest thing in the world that somebody had a profession where they had the ability to help.

somebody come through something that they might not have made it otherwise you know that they could give somebody their life back they could give somebody their health back and give a person's family that too and so I thought it was just the coolest thing that you could offer humanity so there I went and I was actually fortunate, my sister's orthopedist.

I was a really well-known orthopedist at the university hospital and he allowed me to shadow him kind of through college and was a bit of a mentor to me during that time.

I grew up as a mechanic on a farm. I grew up on a farm in Iowa and I thought the fact that you could have a toolbox in the operating room was just the neatest thing ever.

I have always really been interested in physiology. Growing up on the farm, I always helped with the animals and helped with procedures. I'm not surprised that I ended up doing procedural stuff with my hands and working with physiology, but yeah, medicine isn't probably something I would have come to had that circumstance not happened in my life.

Long-winded answer to the question of, oh, I got to medical school. I think it's so fascinating and I kind of feel like a crappy friend because I actually never knew what had happened to your sister that had never come up in all the years that we've known each other.

No, it doesn't make you a crappy friend. I mean, it was something my sister's doing fantastically. She's actually a health coach now and she's doing great.

She, you know, had some struggles through that time, but is doing fantastically. And I guess part of it is that was my initial motivation for doing it.

But the more that I got into medicine, I find the human body fantastically interesting. And medical school was interesting though, because I feel like The reason that I was appealing to the medical school was because I had such a varied background and varied interests and was an interesting person.

And then I got to medical school and I feel like they kind of try to beat that out of you a little bit, or maybe that's just my own subjective opinion.

You know, I was involved in so many things and I was the leader of all these different groups and I kind of. I felt like coming into medicine, one of the things that I could bring was I didn't come from a medical background.

And so I felt like I had open eyes to what the process was. And I feel like med school kind of puts you in a little bit of a weird funnel where at least for me, I.

wasn't able to enjoy kind of that multifaceted nature of my personality or do a lot of other stuff while in medicine.

And I found that really challenging.

When you apply, that's great. That's cool. That's interesting. But like you said, once you get into it, it's so all encompassing that you really have to give up a lot of stuff.

And, you know, I think you and I are both on this journey now many years after residency of trying to reclaim different parts of our lives and, you know, I look back on, you know, things that happened during medical school.

My grandmother died and I remember I failed my biochem test that day that we found out that she died and I went to the funeral and then, you know, I was just right back into studying and just had to move on and I couldn't be like a very good family member because I just needed to get through medical school and there are, you know, many things like that happened, whether it was a family member that died or when my dad had a stroke or friends that things would come up and you just didn't have time to really slow down and be present for a lot of those life moments.

Yeah. I'm sorry to hear that you had that happen. And I had a very similar feeling that you just can't, you're trying to hold on so much that you don't have the latitude to be there as a human, which I think in medicine and medical school, but the entire medical education curriculum does a really poor job of telling us to be there for people all the time, but then not teaching us to be there for ourselves or be there for our people.

It seems sort of backhanded in a way. Yeah, I mean, looking back on it and I know because I'm involved in medical education now that there's movements to change it.

But when I look back to deciding to go into medicine and then kind of the culture that you get sucked into in a lot of ways feel similar to the priesthood or going into serving the church because They kind of teach you to forsake everything else and that you're doing this like very sacred thing, which on one hand, I do think it's sacred.

It is sacred being at somebody's bedside in their moment of need. But at this point, can't we have those sacred moments and not destroy ourselves? We can is the answer we can, but you know, I think when you come up to, there's a certain amount of, I don't know if you got this, but when I was in med school and residency, you're taught to not complain, right?

About the hours or about the work, because the people that came before you had it harder. And so even though you're working 90 hours a week, and even though, I don't know, for me, I developed migraines, I had viral meningitis and I developed migraines in med school.

And they're like, whatever, that's to get through it or figure it out. There's like no time to. Stop or to slow down or to deal with anything. And if you want to complain about 90 hour weeks, well, at least it wasn't the 120 that people were doing beforehand.

And I really. Maybe I'm wrong about this. I haven't seen any data about it, but I don't think. that me carrying a code pager as a first year resident for 36 hours is any kind of a badge of honor.

I think it's stupid, you know? Like I don't want my loved one being taken care of by a first year resident in their 35th hour of work. Nobody works well at their 35th hour of work, but I feel like that's what you're, there's this like pride system that keeps going.

And I suspect it's probably monetarily driven, but ultimately it's pathologic. I don't know. I feel like this is why we're here, right? Is to try to help upend some of that pathology.

Absolutely. And I think a lot of us have been told that it's the only way that the system can work. And part of what we do is coaching and a big part of coaching is challenging limiting beliefs.

## Systemic Problems in Training and Physician Burnout

And I think that's a huge limiting belief that's been placed on physicians and people that want to be physicians that the system can only work if we work you 80 hours a week.

No, that's how the system is currently designed. And there's all sorts of innovations that we could do that wouldn't require people to work 80 hours a week.

And just like you said, who wants their family member taking care? You know, I think about all the trauma surgeons and their 24 hour call. And do you really want to be going up to the OR with somebody that's on their 23 hour of being awake?

I mean, we were on an airplane pilot and frankly, you can't, they have laws that prevent pilots from flying because they know it's unsafe. So this is where, you know, I really hope conversations like this, you know, this podcast is mainly for doctors, but this is an episode that maybe I hope some patients are listening to.

And I really do think it's going to take patients and doctors aligning saying like, Hey, how long have you been up? You know, patients shouldn't have to ask that question, but I think patients should.

And I think we need to start pushing back on that. This is normal or okay to have somebody that's been awake for that long taking care of people. Well, and I think, you know, there's so many things in medicine that the public isn't privy to or doesn't know.

Right. But I think that's a lot of what creates the disconnect between. The medical system and physicians and patients, right? I mean, I'm in the medical system and it's confusing.

I have a master of public health background. And so I did a lot of healthcare economics classes and a lot of healthcare design classes. And in some ways they came out more confused than I went in.

And so I don't expect the general public to be able to understand the deep inner workings of how the healthcare system works. But I think there's some basic things they should be able to expect and.

I think ultimately that's probably a big part of what's going to drive change in healthcare is the public feeling like they have more of a voice in what they're able to choose and in the important stuff to not, you know, does the lobby have a fountain and do I have a swanky private room, but.

You know, what are my physician's outcomes? How long have they been on shift? Yeah. And I would just encourage the listeners to listen to the episode I did with Vinnie Aurora on the emergency mind.

And we debunk a lot of the myths around sleep deprivation and medicine. And the one I really want to just put in the bug in all of our listeners ear is.

When I think back to residency in those 80-hour weeks, if you really had somebody recording what you were doing during those 80-hour weeks, how much of it was actually required work by a physician?

versus how much of it was what we call scut, which is menial labor that does not require a physician. How much of it was making phone calls for follow-up appointments or writing an arduous note because there wasn't a functioning dictation system or scribe.

You look at doctors, you know, if you went straight through, maybe you're 26 years old. If you didn't go straight through, it doesn't matter what your age is.

You have a freaking doctorate. Why do we expect somebody with a doctorate to do all these tasks that could be done by other people and expand the team?

And then people wouldn't have to be awake for 80 hours. You could probably easily shave off. I think if I look back to most of my IC rotations, you could have probably shaved off 20 hours in just pure Scott that could have been

done by a clerk or a scribe.

Yeah, agreed. And also we have to make the process miserable for patients, right? You know, I can't imagine being a post-operative patient. You feel terrible, right?

So say you have appendicitis, right? 20% of us at some point are going to get appendicitis. So, you know, you felt like crap for a couple of days. You haven't eaten anything.

You had surgery yesterday. Your belly hurts. There's some medical student that comes poking around at five o'clock in the morning. because that's what we do, you know, because the medical student has to go and then the resident has to go and then the attending has to go and then they have to write notes and then they come around again.

Why don't we just as a team see the patient once after they've been up for a little bit and save everybody? You know, it's just like you said, I think there's this system that is perpetuated because we think that's how it has to happen.

But a lot of it I think makes it confusing for patients too, right? Because they ask the medical student the question and then they ask the resident the question and they ask it, you know, like, why don't we collectively make this a better experience for patients?

And I think the training in that would create some room for better physicians as well and probably better rested physicians and patients too. I don't know.

We could talk for hours about this. Hi everyone, it's Dr. Andrea Austin. If you've been feeling stretched thin or wondering who you've become in the middle of practicing medicine, Recalibrate might be exactly what you need.

This program creates identity level transformation for doctors because every single participant still practices clinical medicine, yet many have reshaped their careers, their schedules, and their sense of purpose through what they've learned here.

I'm very excited to be co-facilitating the 2026 cohort with the incredible Cherie Johnson, and we've redesigned the program to fit real physician lives.

There are two-hour group sessions twice a month from January 29th through July 2nd, every other Thursday from 3 to 5 p.m. We only have a few spots left and if you've been wanting to work with me individually, this will be the only way you can do it through spring of 2025. Yes, my personal coaching practice is fully booked and I'll only be taking on new clients if you're in the Recalibrate program.

If you want to take your growth even deeper, you can also register for the Heart of Medicine, our once-in-a-lifetime immersive conference in Australia.

a perfect capstone to their calibrate journey. It's unlike any professional event you've ever attended and I'm really excited for the listeners of this podcast to join me in Australia.

Learn more and register at coachingfordoctors.net.au. You may also email me at andrea at andreaaustinmd.com for more information. Yeah, no, I think it's a great conversation to have and I'm reading it takes five to tango right now, which is a book that looks at aligning patients, physicians, payers, policy and pharma.

Those are the five things. And I think there's tons of opportunities for us to build a better system that aligns our interests. Absolutely. Well, let's pivot and talk a little bit about what you've been up to since medical school.

I have been figuring out how to find my place in this medical. How did one of your podcasts get the medical industrial complex or what have you? So I trained in emergency medicine.

So I went to university of Arizona for emergency medicine and I was a chief resident there. Went to a community health system in central Oregon after that.

It wasn't a particularly sick population, which great for Central Oregon, but not great for me right out of training. As you know, in emergency medicine, you know, your procedural skills and things, you have to see a certain volume of rather ill patients.

So I went to a big level one trauma center, got my butt kicked for about a year. It was an interesting experience. It was an academic center and taught me so, so much.

It kind of got taken over by a large management company while I was there that we could talk about if you want to or not. So I ultimately left there because I felt like the large management company and my values were not in line.

And then I went to Guam. So I've been practicing in Guam for six years on and off at a private facility there, as well as a public government run hospital there, which has been fun and lovely.

And last year in there, I had a cannabis clinic. I happened to be in a state that legalized medicinal cannabis while I was in the state and tried my hand at that for a few years, which was a phenomenal experience having my own clinic and Getting to see patients that were really looking for something different in the healthcare system and being able to speak with them in an educated manner about something that.

Traditional medicine doesn't educate physicians very well about was a really neat and rewarding experience. Last year worked in a COVID ICU for six months in the Dutch West Indies.

So that was also a very interesting experience. And more recently I've been doing some locums work and then I'm kind of circling back to my roots a little bit and doing some emergency work in my hometown and then try to figure out.

I got my certification in lifestyle medicine right before COVID kind of came on board. And so that went to the back burner for a little bit in favor of doing emergency medicine.

And then I'm kind of coming out from that a little bit and looking to rekindle the interest in lifestyle medicine. Wow. That's a lot. Yeah, so a lot of stuff.

Yes, I've been doing a lot of stuff as we talk about healthcare and how we integrate into healthcare and how we lead healthcare. I get conflicted because I see the potential for us as physicians and patients to really change the system.

And then in some ways, I also feel like we're trying to hit control. I'll delete on a typewriter. Like, there's this like. we're trying to insert a function into a contraption that is just not built to accommodate what the current space needs.

And so I'm trying to figure out how do I lend myself to that in the best way possible. And I've tried community and private and government and academics, and I really enjoyed having my own private clinic.

And I don't know if that is the best way to do it or not for me.

## Riveru2019s Career Path Across Emergency Medicine and Beyond

And I'm kind of trying to sit and listen for a minute and figure out where I go next. So you and I are both emergency medicine physicians and we've talked a little bit about this offline.

Certainly I've had my periods of burnout with emergency medicine, which statistically 70% of emergency physicians experience burnout. What is that experience been like for you and what are the factors that make emergency medicine so prone to causing burnout in physicians?

You know, I think a couple of your guests on a podcast, I want to say they were on in January, a pair of sisters, I believe Dr. Posh and Dr. Is it Barrett?

I believe had a really good way of putting it. And I think this has been, I think they hit the nail on the head for what my experience has been. I think, you know, I, well, first, when I went into emergency medicine, I heard people got burnout and I just, I thought it was probably due to the volume of traumatic stuff that you deal with.

Cause we do deal with a very high volume of traumatic stuff. And, there's not a lot of way to get around that in the profession that we have, you know, so we have to learn how to deal with that.

I thought that's what it was going to be going in. And then, as I kind of have gone through my profession, I thought, you know, maybe it was the, you know, that I hate the volume of notes that we have to do, or it's the shift work, or it's the, you know, and all the little kind of like detail stuff that are everyday work that grinds away at you.

And I think to some extent that's hard. I think it's hard to work overnight and I think it's hard to do all these notes when you have all these patients to see and things but I think for me it really has come down to a value misalignment.

I feel like the system I value my time with the patients. I value my quality of care. I value the experience that they have. I value how I'm making their life better for some people is going to be the worst day of their life or the worst day of their month.

Or, you know, we have such a privileged and challenging position to get to be the person that helps people through that. And the feedback that I get as an emergency physician is how accurate is my billing?

how many check boxes have I checked for CMS? How can I move more patients through? How can I put orders in on a patient even if it's really uncomfortable for them to have a partial exam done in the waiting room because we are trying to meet our metrics?

And there's just this system that the things that I care about and want to get better at and do better at is not what the system seems to want to get better at or do better at.

And I feel like our patients suffer so much from that. And that's hard. It's hard to come to work every day in a system that doesn't really care about what you care about, or it doesn't feel like they do.

I have a pen in my hand that says patients are partners, right? And you know, I've worked for so many systems that, you know, like integrity is us, but it's not, you know, those are words.

And that for me has been the biggest part of burnout is not having, whether it's the perception of or the latitude to be the kind of physician that I want to be within the system.

No, that was a really articulate way of describing something that's so confusing and messy. I totally identify with a lot of the points that you made.

I think an example is the obsession with the door to dock time. And for people that aren't familiar with that, essentially, I don't know who's decided.

Somebody has decided that patients should be seen by an emergency physician within 30 minutes of arrival. to an emergency department. And it's with a good intention behind it that it's good to be seen rather quickly because sometimes people are more sick than maybe somebody else would have realized.

So it's with a good intention. But, you know, during COVID when we were getting essentially overrun, And frankly, overrun by a lot of people that didn't need to be in the emergency department by people with minor COVID symptoms of runny nose, fever, body aches.

It really was doing, at some point, everyone a disservice. How many times does somebody come up to me and said, like, hey, we need to go see this person.

They're about to leave and we don't want to get a LWBS left without being seen. And I'm actually in the middle of doing something important for somebody else.

And it's just like those constant things that, well, no, no, you got to meet this metric instead of doing what you know in the moment is the right thing.

Like concentrating on this EKG that you're trying to figure out, you know, is this potentially a STEMI, but now I'm interrupted because somebody wants to be seen immediately.

Yeah. And I think that's hard. I, this is a whole, I guess, different tangent too, but it, my capacity to being a caring individual when you're constantly faced with those kinds of things is I feel like reduced, right?

I mean, you get to a spot where people are demanding your attention for things that are not high up on your priority list. And so eventually I get really annoyed.

You know, I get. annoyed at having to go, you know, see this patient because they want to leave or whatever.

## Burnout, Metrics, and Unsafe Staffing in Emergency Medicine

And, you know, like patients don't know that, right? And there's like not a barrier there that keeps you from that door to dock time or that left without being seen or whatever, you know, it's like, it's constantly okay to interrupt you in the middle of whatever important thing you are doing because of whatever other important thing that somebody else thinks is important.

And when I say somebody else, I kind of mean these metrics that have been put in place. You're right with good intention, but don't appreciate that, you know, I am just got sterile for a central line.

You know, I am in the midst of having a conversation with a patient's family. I worked at this place that I laugh about it. It was terrible, actually, that made us carry the transfer phone.

So it was a big academic facility and we across the board accepted all transfers. We never said no to a transfer, but they made us carry the transfer phone.

And so every time there was a transfer, which was, I don't know, anywhere from two to 10 times an hour, that phone would ring. And I would have to take the details of the transfer and occasionally we would provide recommendations or whatever, but we kept trying to get a system in place because as you know, as an emergency physician, when you're working at a busy place to have a phone call 8 to 10 times an hour about some other random thing that wasn't on your plate beforehand that you just have to say yes to.

get somebody to answer the phone. If they have a medical question, I'll take it. But, you know, it's not that I'm opposed to taking it, but I have other things I need to be doing.

And I don't feel like the system respects that a whole lot. Yeah, and it's interesting now what I've been trying to do when I get this really annoying interruption that's something small.

I've made some decisions that actually I'm in the middle of something. I'm having a conversation with a consultant or I'm in a patient room having a moment with them.

They're gonna have to wait. And I found that by regulating myself a little bit more of like, no, I'm not going to go do this other thing. until I'm ready, I can show up a lot better because when you yank me out of something that was important and then you tell me to do something to meet a metric, I'm not really, honestly, probably my best self when I go do that other thing, where if I had a few minutes to tie things up, then I can go into that room calm and

more compassionate that somebody has a runny nose.

Well, and the metrics aren't always the best thing for the patient. I think again, you know, sweeping things are with good intention, but you know, I can't tell you how many times when I worked at a super busy facility that I would walk into a room and a patient had vancomycin running and I'm like, why does the patient have vancomycin running?

Or I would walk into a room and the nurse is giving five milligrams of morphine for somebody that smashed their finger in a door. I'm like, why are we giving five milligrams of morphine?

Well, because we have to meet our long bone fracture. time to narcotic by whatever and I was intubating somebody so I couldn't meet our long bone fracture.

You know it's just like so many of these things where I'm like well now my patient just got a narcotic they didn't need or they just got an antibiotic they didn't need and you know a lot of these aren't being driven by thoughtful physician decision making it's being driven by some metric that we have to meet and it's just I don't know I feel like the part of the reason at least in my case the places that I worked is we're just understaffed and that's a whole other thing too right is you know nurses have ratios doctors don't and I have worked at several facilities that have.

very, very poor staffing. And that for me has been a source of burnout also. It's just the expectation that you can see unlimited numbers of patients and that, you know, you can see them very quickly.

And it's hard to process for complicated patients an hour for 10 hours. Yeah, that's such a great point that you bring up. And it's something that I've said many times.

What is my ratio? And we don't even actually have data on what is a safe ratio for physicians. And it's time that we do that research. And we know I've had times where I've had 50 patients that are under my name.

Now, maybe I've had some. advanced practice, APPs working with me or residents. But at the end of the day, it was my name. I was responsible for all of those patients.

And I personally just don't think that's a safe way to do things. Or right, designing a system that would not be the way you would design it. It's not, you know, it's so hard, even when we have the time, you know, with our patients and stuff, people are complicated, right?

The human body is complicated. There's a reason we went to school for 12 years to do what we do. The human body is complicated. If your expectation is to be able to pick up 50 complicated things on patients at once, nobody can do that.

And. Yet I feel like we're asked to do that, not infrequently. And I think that is really challenging and frankly, very unacceptable and dangerous. And I've been in that position myself and it's so uncomfortable to know that you're probably, you don't have the capacity to do the best you can for every patient.

Cause you just don't physically have, you can't, you can't do the best thing you can for 50 patients at one time. You just can't. So we're going to leave it there for this week.

It's not lost on me that we got a little negative towards the end and some parts taken out of context could be misunderstood. I know River really well and we're both proud emergency physicians and we take pride in being there for patients 365 24 7. We are the only doctors that are.

We are the only people that are there for everybody, regardless of their ability to pay. And that's why we chose to go into emergency medicine. But the safety net is frayed, and we need everyone to be focused on ways to better support us and provide us the resources, staffing, physical supplies, workflows, working as a team in the hospital, recognizing that we can never close our front door.

Patients continue to come in, and the only way things work is if patients, when they need to be admitted, move upstairs. And when patients need to be transferred, that ambulances are available to pick them up and safely take them to where they need to go.

So you did hear some frustration. You did hear some questions of, How can we be the wealthiest country in the world and still have these issues and be burning out our physicians?

So coming back full circle to why Linda and I founded Revitalize is we are tired. of being tired. We are tired of hearing these stories over and over again.

We'll keep listening because part of this is that we want to be alongside you and I'm still complaining as well. But there gets to be a point where it's like, we can't continue down this road.

There has to be a new way. And we hope that Revitalize is part of that solution. We believe that more of us coming together and getting clear on our values, you heard River say that several times during the pod, that I was working in a place that wasn't aligned with my values.

So recognizing your values, recognizing boundaries, and then lastly becoming that leader that when you are in a system that is not toxic. We're always going to recommend that if you're in a toxic system that you leave.

But if you're in a system that's just not working well, but it's not malignant, it's not pathological, there's some good people that need help. We hope that the tools that we have at Revitalize empower you to be able to make the changes because we need you.

Your patients need you. Your communities need you. The level of expertise that all of you have is enormous and not replaceable. A lot of people are trying to tell you that you are replaceable.

You are not. So I know we got a little dark in this episode and that's okay because we don't believe in toxic positivity. We want you to show up and tell us what you're feeling.

And after we get that out, we're going to pick ourselves back up. We're going to support each other. And I believe we're going to make health care better because we've got to.

## Closing Reflections on Revitalize and Healthcare Change

We've got to do it for ourselves and we got to do it for our patients. So I'm sending you an air hug and I'll see you back on the pot next week. Thanks for listening to Heartline, Changemaking, and Healthcare.

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