The Remarkable Journey of a Transplant Surgeon with Dr. David Weill (Episode 88) Transcript

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Introduction and Dr. Weilu2019s Background

While we're making a podcast first for me, this is my first interview with a transplant surgeon. I am so excited to have Dr. David Weil, who's dedicated his career to the transformative field of organ transplantation.

As a former director of lung and heart lung transplant program and founder of the Center for Advanced Lung Disease at Stanford University Medical Center, he has firsthand experience with the challenges and triumphs of transplantation.

Today, he supports patients, families, and transplant teams in navigating their transplantation journey to achieve the best outcomes and I'm also really excited to share with our audience that he's also a doctor author, which listeners know that's one of my favorite groups to have on the podcast.

And he'll be talking to us about his book, All That Really Matters, and we'll talk more about that. Dr. Weil, it's great to have you on the podcast. Thank you for having me.

I'm looking forward to it. Well, in tradition, we'll start with the question I love to begin with, which is, why did you become a doctor? OK, I've got a boring story here.

I'll move right through. I'm the only son of a nurse and a doctor. And so I was around medicine and medical people since I was born. I worked in hospitals starting at age 15. I love the hospital environment.

I never considered doing anything else. And I was somebody that was lucky enough to be exposed to medicine from an early age. So for me, coming a doctor was the only thing I wanted to do.

Well, maybe the follow-up then is why did you become a transplant surgeon? Because I think any physician, we all have our challenges within our specialties.

I had a little bit of exposure to transplant on my surgical rotation. And I remember thinking like, oh my gosh, like transplant surgery, that is so intense and so hard.

And some of the operations are so long and so unpredictable that it is akin to maybe neurosurgery is one of those specialties. When you hear you're just, whoa, like what happened there?

Like you have to, and I guess external perspective is you give up so much to do that type of work. Yeah, I ran into transplant by happenstance. I showed up for my internship literally the first day, July 1st.

And the program director got us all together and basically said that somebody had gotten sick on the kidney transplant surgeon that was a fifth year resident.

obviously five years ahead of where I was at the time, but they needed an intern to kind of do some of the scut work on the service and were there any volunteers and I shot my hand right up and so I was hired immediately because I was the only one that raised my hand and I started off my internship on the kidney transplant service and the first night that I was on the service the team did a kidney transplant and my job was to make sure the guy filled up the poly catheter bag after the surgery.

And so I sat there all night and watched his bag fill up with urine and a guy that hadn't been able to urinate in 11 years.

How He Became a Doctor and Transplant Surgeon

And it was just the most amazing thing. And I was impressed by the fact that with one operation, you change the direction of somebody's life like that.

And I was hooked immediately. I didn't ultimately go into kidney transplant, was doing my lung training in a place that was developing lung transplant at the time.

The field was in its infancies. This was back in the early nineties. Lung transplant was just becoming a thing in America. And I was at the University of Colorado, right place, right time.

And so started training in lung transplantation. Wow. So it sounds like you have this predilection towards innovation and being at the head of the curve for an early adopter.

Yeah. But I bore kind of easily, which is a real poor character trait of mine. But the one thing about transplant that really lasted throughout my career in it is I never, not one day did I not want to go to work.

Or did I think that what we were doing was unimportant? I never set an alarm clock during the entire career and really very much look forward to going to the hospital every day.

I love the fact that I was in a position to be able to kind of make up some of the stuff that we were doing as we were going along. The field was so new that it was basically just following common sense.

We didn't have a playbook. We didn't have protocols. We didn't have a lot of data. We basically just tried to think our way through the problems and use common sense.

And that really attracted me to the field. One of the fun parts about having a podcast is I get to ask people from different specialty questions that I should probably know or could have probably looked up.

What is it about lung transplants that makes it so challenging? Because from my perspective, and certainly catch me up if I'm wrong, kidneys and hearts, they generally go pretty well.

The lung transplants tend to, the last time I looked, the longevity of those are still fairly short. Like what's so different about the lungs? I think it's not so much the surgery as the afterwards.

I think that the lung is particularly susceptible to both acute and chronic rejection. It's also open to the air, unlike the other transplanted organs.

So various infections come into play as well. So the medical management of those patients, beginning in the ICU and beyond, is really difficult. And I think that We haven't seen the kind of kidney transplant survivals and lung transplant yet.

I'm hopeful that we will one day, but it's not there yet. It's just not like getting a kidney transplant. So even though our patients face certain death, usually within a few weeks when we put them on the waiting list or a few months at least, We feel like we give people enough time back where it makes it all worth it.

And in fact, we sometimes go back and transplant people a second time and even a third time these days, because the graft doesn't last as long as it does in liver, heart, and kidney, to your point.

I think it's getting better, but it's not getting better fast. We're not making like leaps and bounds progression from year to year, but there's a lot of people working on it.

Yeah. Thinking back to my medical training, so as emergency medicine, we do spend a fair amount of time in the ICU during residency. And I took care of a lot of patients that were receiving liver transplants.

That was a big organ of emphasis at the facility that I was at. And it seemed like there was this paradox in transplant. And I wonder if you can speak to this.

You have to be so sick because of the scarcity of organs that you have to be so sick. By the time that some of the patients were getting it, it was kind of like, are they too late?

Can you speak to this challenge in the scarcity? And I mean, I know it's a complicated thing, but What is your recommendation to these organizations that are making the rules with balancing that line between when someone, they of course need to be sick, but if you wait too long, they're too sick?

Yeah, it's a tough problem and one we've struggled with since I got involved in transplant. We call it the transplant window.

Why Lung Transplantation Is So Challenging

You're not too well and you're not too sick. So you're really threading a needle and that's much more art than science because one of my main jobs throughout my career was to decide who and when to put a patient on a waiting list.

And I did this calculation every day, and sometimes it was a data-free zone calculation where I was trying to figure out, are we transplanting this guy or this woman too soon, or are we transplanting her too late?

And we also know that we have to build a waiting time into that decision-making process that is also unknown. So there is a fine line that you have to kind of walk and it's very difficult to do.

And I think that the organizations that are in charge of kind of making of various allocation schemes and who goes first and all that sort of thing has recognized that When we get to the point of a patient being so critically ill, the outcomes are going to suffer and we might not be using the donor organs available to the best possible way they can be used.

And I think the field has always struggled with this. And I think it's largely because we don't have tons and tons of data. about all of these areas. I'm hoping that AI actually can help us out in trying to figure out when is the optimal time to transplant somebody?

Because I think that's, it's an age old question. I don't think it's ever going to go away. I don't think we're ever going to have like the solution on it.

I like to think that I would just bring my judgment to the table. And judgment is a very difficult thing in medicine because you can't often give it to somebody else where you would just have a sense that this person needed to be on the list like right now versus could you identify the people that could wait a little bit longer?

And I did that all day long and thought about it all day long. And it was probably the toughest part of the job, frankly. Yeah, I'm curious about that.

And I don't think there's anything quite akin to that in emergency medicine. I think the closest thing would be when you're triaging people and you decide who goes first and you're making judgments on that.

And we try to say that it's as objective as possible. You're using vital signs and other things. I've been pretty fortunate that in those type of situations where triaging was truly critical, I don't think there was a lot of time or even after the fact to really question.

I think the adage of you do the best that you can, but I'm wondering, because what is different compared to my specialty to yours is you get to know these people and you're intertwined into their lives.

So I'm curious, and this probably gets into some of the themes around burnout, is how do you manage that

throughout your career with making these tough calls, especially as you got to know the patients and their families?

Well, that topic is nearly the entirety of my first book, Exhale, that I published in 2021. It was all about the emotional rollercoaster of doing this kind of work, where we get to know the patients to your point very well.

We would know their families really well. I mean, we knew their docs names. I mean, we didn't have thousands and thousands of patients to keep up with.

We had hundreds, but we got to know them really well. And it's an advantage in many ways. I mean, I've often thought about ER medicine. I'm not sure because you have that snapshot in time.

That would be hard for me to be able to practice medicine that way because I really took advantage from a clinical standpoint of the longitudinal nature of the relationship between me and my patients.

But from an emotional standpoint, that's something different altogether. I became very emotionally attached as I wrote about in my first book to our patients.

And when we lost them, it was devastating to me and eventually got me out of the front lines of transplantation because I could no longer tolerate the imperfection of it.

It's an imperfect field. It's not going to go right every single time, but that didn't mean that I didn't want it to go right every single time.

The Transplant Window and Tough Timing Decisions

And I think, That was something that I could do really well when I was younger. I could, seemingly I could go to the next patient more easily. But as I got further and further into the career and about 20 years deep into the career, I had trouble tolerating patients, losing patients.

I didn't have a great way to deal with that any longer. So I decided for me, it was time to step out. And I know you've thought about this a lot and you've written about it and you've gotten to watch so many other physicians and surgeons.

Do you think there's anything that the system could have been designed differently that could have allowed more space to process that in time and could have like prolonged your career, the people coming behind you.

Like I think about that a lot right now in emergency medicine because a lot of my colleagues are saying, We don't actually think we can do this for a full career.

And maybe this is only going to be something we can do under this intensity for a decade, which from a workforce standpoint, and when you think about a transplant surgeon, my goodness, a lot went in to make a transplant surgeon.

Well, I thought a lot about all of those issues. I had the sense pretty early on in my career that there was going to be a shelf life to it. I just thought for me personally, I was going to develop a chapter two, a second act.

And for me, that came at age 52, a little bit earlier than I thought it would come. But that's when it came. When I stepped out of there, I was 50 years old and that's fairly young to lead one's primary career.

I've developed a secondary career, but I think it was very difficult for me. And now as I consult with transplant programs and work with teams to get them better, I see a real problem.

I mean, not only among the workforce that's currently present in our field in transplantation, but also we're not really attracting people to the field in nearly the numbers that we need.

And I'll work with programs every day that are trying to hire physicians and surgeons that can't find them anymore. I don't think the younger generation is as interested in transplant as my generation was because they look at us and they say, well, I don't really want that life.

And I can't say they're wrong. It's tough on me as an individual and the people that practice it, but it's also tough on the people around us. My wife and my kids and everybody else is impacted by it.

So in our field, it worries me quite a bit. And in fact, I've written about, we need to have less transplant programs because we don't have enough people to staff them anymore.

And I believe pretty strongly in that. And that doesn't give me a warm and fuzzy feeling because I think the field needs more and more people. But until we make the job more doable, It's not gonna happen.

I think you mentioned burnout. I think burnout is fairly well misunderstood as an entity. And I read about this in my first book. I don't think I was suffering from burnout.

I think I was suffering from being a human being. And I think that what you're seeing, I think, in the healthcare workforce, if I could generalize, is you're seeing less mental health issues because I think people thought that burnout was an internal issue.

It was specific to me or to you. I don't think so. I actually think that it's an ecosystem problem in health care. I think that at least among the physician teams that I work with, they're working in a system that isn't a system at all.

It doesn't work for the practitioners or the patients particularly well. And I think what you're saying is, and COVID, I just think exacerbated it, but it was certainly going on well before COVID.

I think what you're seeing is a broken system that isn't a great place for people to work. Again, after my first book came out, I had thousands of emails and social media messages.

How do I get out? That didn't make me feel very good because I don't want people leaving medicine and drugs. I care deeply about not only medicine, but transplantation.

I love it. I think it's the best thing ever. If somebody said, would you want to do it all over again? I would say absolutely. I mean, it's magic, but it hurts that The system isn't such where we're attracting a 35-year-old, a 30-year-old, a 25-year-old to the field because of what we're asking them to do.

That makes the field at real risk because, again, there's just not enough people to go around to staff these programs. Yeah, I think you've articulated the same conclusion I've come to and I'm excited to give a talk later this year called Stop Calling It Burnout, It's Moral Injury.

And I'm guessing you're familiar with Wendy Dean's book on moral injury and it's, I think we all need to start calling it what it is, and it's essentially not being able to meet our ethical duties in a way that we can keep our own oxygen masks on while doing that.

Burnout, Moral Injury, and the Cost of the Work

And we've gotten really good at bootstrapping. So we're very good at always being the glue in this system that's cracking. And that's not a sustainable system.

And the people coming behind us are like, wait, now I'm actually not going to do that. So I think we're at a real inflection point. And I'm glad that the language is changing and more people are saying like, let's not even use the term burnout for this phenomenon.

I think that's right. I wrote a piece. I can't remember where it was published, but it's on my website. where I wrote about Lorna Breen, another emergency physician that I'm sure you're familiar with her story.

But it really brought to the forefront, I think, her situation that immediately everyone thought, oh, okay, well, this was just a doctor suffering from depression or whatever else.

No, she was suffering from a situation that was undoable and she reacted in a way that was a very human way to react to it. But I think it was too easy for too many years just to say that something was wrong with the doctor, that she was somehow not up to the task.

And I think there was too much of that early on, but I am glad the language is changing. I do think Wendy Dean has been very helpful. in getting that message out in a variety of ways and others.

But I think the language matters because it's, barred out is a term that really implies something's wrong with the individual. And I can personally attest to that's not the case.

Yeah, so let's move to your writing journey. And the book that I read was your fiction book, but maybe we could actually start just a minute going backwards in time, going through that period of time that you transitioned out of direct patient care.

And then I imagine that's where the nonfiction, the memoir book came. Just tell us a little bit about your writing journey or how writing has weaved into your story.

Yeah, so throughout my career at Stanford, I scribbled a lot in a journal, just whatever was happening that day, either with a particular patient or within the team.

I was very interested in the team dynamics. We had 55 people on the team that I directed, and I was very interested in all of what was going on with them and us.

And so I'll write in this journal. Then I took a few courses at night at Stanford in the English department just to get a feel for how do you do this if I want to do this.

And it was kind of just a pipe dream at that point. And then when I stepped away from the front lines, this was in 2016, I had a lot on my mind. I mean, a lot was going on then.

And I decided I was going to take a crack at kind of peeling back the curtain of what it's like to do this kind of work. And I decided early on that I wasn't going to sugar cut at all.

Like I was going to really say all. And I was going to expose myself. I was going to expose the hospital ecosystem, all of it. And a lot of it was not just negative stuff.

It was very uplifting things that the patients would experience. What happened to them when they got this incredible life reset? But I wanted to tell the whole story.

But I also wanted to show what was happening behind the scenes when you're trying to deliver this kind of care. Cause I think most of the public, I mean, some of your listeners may know it, but a lot of the public doesn't really understand who are they looking at when they're in the clinic room.

Who are they sitting across from? What has that person's day been like? What problems do they have to overcome? What obstacles are put in their way? And I wanted to actually show all that.

And the feedback I got from the book is, wow, I didn't know that all that went on. I think it surprised a lot of people with the hospitals are complicated places, trying to deliver a complex care.

It's hard. And there's a lot that goes into it. And a lot of patients and their families were surprised to learn that it wasn't all about them. In other words, not everything that happened all day long was about, well, it's all about getting the patient better.

It's not, right? I mean, there's a lot of other stuff going on that has nothing to do with delivering patient care, which is unfortunate, but it's a reality.

So that's what the first book was really geared toward is telling that very personal story, the journey I had in a field that I love very much, but had to walk away from.

Did you find it therapeutic or was it meaning making as you started this new pathway? Yeah, I mean, there were times when I was crying while I was writing.

Some of the stuff that I read, I read a lot about my father who got a liver transplant early in my career and really changed the way I thought about transplant.

I was only about five years into my career when he got transplanted and now I was… a family member of a transplant recipient. He and I were really close.

And I talked a lot about that. How did that relationship change the direction of my career? It changed it a lot because it became very difficult for me to distance myself from the people we were transplanting because my father had just gotten a transplant.

Now everybody was my father that we transplanted. And so doubled down. I was already very into it, but I think I doubled down on it after he got transplanted and it became more religion and the mission became the most important thing in my life, quite frankly.

And I talk a lot about that in my book because I think it was important to how my career went. Talk about the pivot, or if it was a pivot, some authors stay in one genre and write nonfiction.

Certainly there's probably a multitude of nonfiction books within you, given your expertise and experiences. What made you write a fiction book? I mean, were you a literary person that you read lots of different books and, or just say more, but I'm so curious.

Yeah, I do read a lot. I read about half fiction and half nonfiction, I would say, and I've been doing that for years. My mother was an avid reader, so she got me involved in reading when I was very young.

I'm not a very literary person, I don't think. I feel like the novel, all that really matters is less literary fiction than it is story. I hope people want to turn the pages.

I hope they're interested in what happens. I don't think it's going to be confused with War and Peace or anything like that. But I hope it's a book that people want to reread it.

They want to keep finding out what happens to these characters. I was really interested in writing fiction because I had written a memoir that I thought told a lot of the story, but there were still some parts of it, some crevices and corners of the hospital ecosystem and the way all of us do our jobs in healthcare that I didn't get to in the memoir.

But I feel like I got to all of them in the work of fiction, because frankly, I had a lot more latitude to get there. When you write a piece of nonfiction, you have to tell the truth, first of all.

You try not to offend the people that you work with. You try not to be defensive or call out an institution where you worked. In a novel, you don't have to worry about all of that.

Writing Exhale and Turning to Fiction

I found it very liberating and freeing to be able to wander around into all of healthcare that I knew about, that I saw either in my day-to-day practice or in my consulting work I do now.

And it all ended up in there. And I don't think I could have done that with the work of nonfiction. for all the reasons

that I said. So I loved writing the fiction book.

And as a fact, I had more fun writing my novel than I did my memoir. My memoir was more therapy and spilling it on the page. Whereas I actually had a good time writing my novel.

I enjoyed making up the characters and basing it on things that I had seen, but going here and there and not knowing where it was going to go next. I really enjoyed it.

It was a blast. My third book I've signed a contract for, I'm already back to nonfiction. So I've already realized I'm in the midst of writing and now that how hard it is to write things and stick to the truth and pick the facts and show it how it really happened.

It's a different thing. Yeah. Well, that is awesome. Can you give us any inklings on this third book or just stay tuned? No, I can give you a little bit.

I feel like in my first book, I covered how we relate to our jobs. In the second book, it was my character is dealing with these high expectations and life and death situations.

And so I decided in my third book, I was going to do something really easy and write about religious identity. So for some reason, I want to tackle really kind of tough subjects.

Yeah, this book is about my own struggle with religion and religious identity. And it's even more broad than that. It's really about identity. Like, how do we, when we wake up in the morning, we look in the mirror, who do we see?

And when you write a book, you have to be sort of obsessed with whatever the topic is. And I really am kind of obsessed with it because You probably have an identity you think of yourself as X.

And it may be that other people don't see you that way. And I think of myself in a certain way. In a lot of my life, my identity was transplant doctor.

And that was the first thing that I thought of. But I really got interested in this question of religious identity a long time ago because I come from a fairly ambiguous religious background and didn't have formal religion in my life when I was growing up.

And it impacts you. It changes you not to have that. And so I really started exploring it. And so this is more, this will be more memoir and narrative nonfiction that I'm working on now.

And it's hopefully going to be interesting, but we'll see. I think you have a pretty good track record on interesting books. Nice to say. Yeah, yeah. Well, what advice would you have for a physician out there that's struggling?

I mean, you said you get a lot of emails from people like, I want to get out of this. And so what's your advice for physicians that are maybe feeling this moral injury that we've described in the episode?

And they maybe still have quite a bit of student loan debt to pay off. And so they're not really at a point where they feel like they can leave. Right.

That's an important point. I mean, not everybody has the luxury of walking away if they want. To me, and this is again, this is just my recipe. This doesn't have to be anybody else's.

It came down to the three F's and it's family, friends, and faith. I think. When I struggled the most in the hospital, I got isolated and away from those three things.

I didn't engage meaningfully with my family. I would come home. I had the hospital on my mind. I would sit and bury my face in a book or watch a game on TV and didn't interact much with the family.

They saw it. I saw it. I knew I was doing it. But I was emotionally done for the day and I didn't have anything left. And that was a mistake. And the thing could be said with the way I lost contact with my friends, the people that were the most important to me.

And that, that, that was isolating. And then from a faith standpoint, I don't necessarily mean religious faith. I mean, having the sense that there's a certain calmness and spirituality and serenity.

And if you find that in meditation, fantastic. If you find it in an exercise, that's great. If you find it in a church or synagogue, that's also great.

I kind of toward the end of my run in the hospital lost all three of those connections. And I guess I would encourage, and I've actually gone around and talked about this quite a bit at medical centers, I would encourage people to every day, foster all of those three F's.

Make sure, and if you like a checklist, make a checklist. Just make sure that you're doing all three of those things every single day. And I think that's probably the best way to keep yourself emotionally healthy.

My conclusion about healthcare is a little bit dark. I don't think it's, Any of us should be waiting on some big massive fix to it. I don't think it's coming.

I hope that doesn't disappoint. Maybe all your listeners already think that, but for a long time I was hopeful that, well, we should be able to fix this.

I don't see it out there. I don't see the way forward for healthcare to get to a point where it works for the patients and the people providing the care.

I don't see it right now. Maybe it's out there. I just don't see it. But I think we have to take care of ourselves. It's up to us. And the best way to do that, I think, is to stay in touch with your family, friends, and family.

It's the only way I know how to. Yeah, I mean, I think that's a very pragmatic answer. And I don't think anyone listening is, I don't think we have any Pollyanna's that listen to this podcast.

What I like to frame for people is I do think we're living with a large dilemma. If it was a problem, it would have an easy solution. This is a dilemma.

I think everybody has to meet themselves where they're at. I've worked in a variety of different institutions. I've deployed with the military. I've worked in India in a nonprofit hospital.

A New Book on Identity and Religion

What I find fascinating and one of the things I want to write while talk about my lecture on moral injury is some of the areas that were the most Resource limited in which you would think that perhaps the moral injury would have been perceived as the highest or actually the least and what I've come around to and I think is happening and I can tell from one of the themes in your book I'd be interested to hear what what you think too is When I worked in a county hospital, it was pretty clear, like, this is how many beds we have.

This is how many patients come in each day on average. And because of this, there's no possible way that we can admit everybody with this condition. Since that's the facts of the situation, Here's how we manage this issue." And the rules were actually very clear.

It was very clear, like, if their heart score is this, they go to the observation unit. If it's this, they're admitted. And there was a pragmatism there that was like, if we didn't have these rules, it would be chaos.

And two, we actually are the county hospital taking care of some of the most deserving patients. And if we weren't doing this, where would they go? So it was interesting that my moral injury in that environment was lower than in

some of the other places I've worked in, which I felt like we actually have, it's very resource.

There's a lot of money in this place. The lobby looks like a hotel. I'm aware of various leaders packages for compensation. And so I'm curious at all, like what your sense is of that.

And I don't know, I've kind of just gave you a lot to unpack there, but if there's something to that. Yeah, no, it's really interesting what you say. I've found a lot about that.

I mean, I practice medicine. All the way over here, right? I mean, I was in a very expensive therapy. People with really good insurance got it. It was practiced in very fancy facilities.

It was coronary care and yet it was at times a very unhappy work for us working in that field, at times. There were other times when it was magical and beautiful and seeing people get transplanted is a lovely thing.

But I've often thought about the people working in county hospitals and I've had the occasion to visit some of these places that deal with underserved populations, both here in New Orleans and in the Bay Area.

These are some of the most satisfied people in healthcare that I know because I hear from the others that aren't at all. So I think there is something to it that they're probably, those folks are probably closer to the reason they went into medicine in the first place than those of us who practice this very high-tech, very expensive, innovative, fast-moving kind of field.

And I'm not saying one's better than the other. They obviously both have roles. But I think there's something to your point about getting so close to making a difference, which is why all of us went into healthcare.

I mean, I think when we lose that making a difference attitude, that's where we get into trouble. And maybe the folks who work in these resource-limited areas, they don't lose it.

They're always making a difference, and they know they are, and it's uplifting to them. That's been my personal experience. I mean, it sounds like it might be yours as well.

Yeah, definitely something to ponder. I think all the fulfillment literature, the more mission aligned that you can be is certainly a recipe for more fulfillment.

So some of that I think is reframed by the individuals because certainly some of the affluent communities that I've worked in. Well, kind of the great thing about the emergency department for better or for worse is it's kind of the equalizer.

So you do get all kinds depending on where you work. I want to end the podcast on maybe a happier, lighter note.

Advice for Physicians and Finding Fulfillment

So one of the questions I like to ask is, what are you optimistic about in 2024 or something that you're looking forward to? Well, one thing that I'm looking forward to personally is spending more time with my wife because we're empty nesters in August.

So I'm looking forward to that personally. And I'm very much on a professional standpoint, looking forward to writing this third book that I'm interested in.

So I'm very much looking forward to that. I think also what's great about where I'm sitting right now, and I feel really lucky to be able to do this, is I can take my experience in transplantation and bring it to other hospitals.

I just got back from Abu Dhabi in the United Arab Emirates, helping them with their transplant situation. And I feel very lucky to be able to do that, to be able to take what I've learned and bring it to other hospitals.

So I have a lot to be thankful for, both personal and professional. So your book is All That Really Matters, and where can people order those books? Really wherever books are sold, they're obviously available online.

I'm always interested in getting the independent booksellers more business. So I encourage your readers to go that route if they can, but it's certainly available.

Barnes and Noble, Amazon, wherever you buy books online. Yeah. And I believe for our listeners that would like to buy online and still support a local bookshop, there's a website called bookshops.org.

That's a great option as well. And then you said you provide consulting services for transplant services. Is there any other type of coaching or consulting that you do like individuals?

Yeah, I do some of the individual.

Looking Ahead and Where to Find His Work

Helping them out really with all kind of different issues related to workplace activities. I can be found at davidwild.com and it's got a full sort of range of the things that I do.

But most of what I do is help transplant programs that are having struggles, either clinical, administrative, team dynamic issues. You name it. Whatever problems transplant programs run into, my consulting group helps them and I've got five other people that work with me.

So it's been a great experience. If I can't directly help transplant patients, I'm glad that I could help the programs that help transplant patients. So it's been great.

Absolutely. And I'm so glad that you're sharing your wisdom with the world. There's a book that I love and I can't think of it right now, but I'll put it in the show notes.

And it talks about these different arcs in our careers. And that wisdom generation phase is a really important one to cultivate. And just like you said, one of the things we didn't touch on today is I'm a simulationist.

And so I would love to have you back to talk about what you've learned about team dynamics, because this is all interconnected. We can't have well individuals without well teams, and well teams drive well organizations.

So I just think it's amazing what you're doing through writing books, coaching and consulting to hit that single double, triple loop learning that we need in organizations.

Well, thanks. It's been a privilege to do all of it. So I feel lucky. Well, I hope to have you back and thank you for everything that you're doing. Thank you.

I enjoy the conversation. Appreciate it.