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THE BUSINESS OF INDEPENDENCE: PRIVATE PRACTICE DONE RIGHT WITH TERI YATES

David Mandell:

Okay. Hello, this is David Mandell, host for the program. Thanks for joining us, whether you're on YouTube and you can see mine and Teri's smiling faces or most of you I'm sure just listening on the podcast networks and platforms. I've got a great guest today. We're going to learn a lot. Let me tell you about Teri Yates and then we'll start in. So, Teri is the founder and CEO of Accountable Physician Advisors, a consulting firm that helps doctors be successful at the business of medicine while maintaining their independence. Teri describes herself as a private practice evangelist, and I love that. And since she started her journey in 2013 as a one-woman consulting firm, Teri has launched two additional companies focused on serving the needs of private practice physicians. Collectively, Teri's companies provide services to more than 90 aspiring private practice physicians and established medical practices over the last 12 years. Her companies employ more than 45 people with diverse experience and expertise in business development, healthcare operations, healthcare finance, and revenue cycle management.

In her personal consulting practice, Teri focuses on business strategy, physician leadership development, and practice governance. She's a frequent guest on podcasts like this one and a speaker, and I met her at a medical conference where we were both attending and presenting. And before launching the Accountable family of companies, she worked for 17 years in executive leadership positions with hospital-based and outpatient

radiology practices. So, with that, Teri, welcome to the program.

Teri Yates:

Thank you so much for having me.

David Mandell:

It's great. It's great. I know we talked about doing this and now we finally got it done, so that's great.

Teri Yates:

Absolutely.

David Mandell:

All right. So obviously we're going to put a link to the full bio. I cut that down just for time period. We'll put that in the show notes, but maybe you can flesh it out a little bit. How long have you been in the field? What sparked you to branch out and form your own firm, Accountable Physician Advisors? Give us a little bit of that story.

Teri Yates:

Sure. So, I've worked in healthcare my whole career. It's all I've ever done. And in just different types of settings. And when I was early in my career, I actually thought I wanted to be a nurse when I would grow up. And so, I went to nursing school for a couple of years and then I decided to change majors into healthcare administration because I thought I didn't want to be bossed around by doctors every day. And as it turned out, then I spent the rest of my career in service of doctors, and that's what I'm really passionate about and love to do. And so, as you said in my bio, I've worked in a lot of different areas, but I've never worked for a hospital in all of my career. I've always been in the outpatient settings. And the last job I had before I started my consulting firm is I was the chief of quality and risk and compliance for a group of 150 physicians.

When I got into consulting, it was because that large physician practice, which was private equity backed, was not generating the returns for their investors that they were hoping for. And so, a third of the non-physician workforce got laid off and I was one of those individuals. And I thought, "Well, I'm pretty type A and I'll do a little consulting on the side while I'm looking for a real job." But I quickly realized that there was such an exciting opportunity and it was so fun doing the work that I'm doing now. And so, I figured out this is my real job and I've never looked back.

David Mandell:

Yeah, that's great. Yeah, I like that term, real job. That's a good one. But yeah, it's quite an entrepreneurial story you have too. You could see here it in the bio and how many people work for and with you on your teams and that you started just as a solo person.

Teri Yates:

Yeah, this was a side hustle in my spare bedroom. And a lot of people worry, I think, about leaving the security of the corporate world, but the truth of the matter is it's been a long journey, but after about two or three years, I came to understand that it was a good bet to bet on myself and that I've had more job security and comfort than I ever felt working for someone else because I can make all the decisions and I can make the decisions I know are going to be best for my clients, which is where I think long-term success comes from. That's why I called my company Accountable is because we're accountable to our clients. And if you do the right thing, I believe that good things happen for you.

David Mandell:

And I'm sure that that translates in how you talk to physicians, especially those who may be thinking about branching out and starting their own practice, who've been in a large group and that's not working for them, and they want to do their own thing. And you can tell them from experience that it's not always easy. It's not always fun to be the boss, but it can be done and can be done successfully and in a way that's rewarding. So that brings me to

my first real question, which is let's start with, because you work with practices in a lot of different stages, let's say. So let's talk about, and I didn't plan this being a segue, but it sort of is, is that new private practice, whether it's a doctor just coming out of training or as we were just talking about leaving corporate practice or a large group and then having the confidence to come out and start a practice, what are the key checklist items? What are the priority must haves or must avoids that you're talking to those kinds of docs about?

Teri Yates:

Sure. And we start between three to five new medical practices every year. That's part of our business. It's not all of our business, but a lot goes into it. Our typical client who does this is usually someone who's been out for a little bit. They're maybe in their early 40's and they took a job either as a hospital employee or maybe employed by another group, and at some point, they've gotten the itch to have more control. That's usually what it's about autonomy. And so, when you start a new medical practice, there are several dozen steps and tasks that have to be done, but the most crucial place to start is a financial feasibility study.

First of all, determine if you should do this. Is it wise to do this? And then you've got to figure out how am I going to finance this? Do I have my own money that I've saved? Am I going to need to borrow? What should that look like? And how much to borrow, which is one of the things you learn when you conduct a feasibility study. Another place that everybody thinks about is office space. And should I rent office space or should I own it? Because owning real estate can be, if it's done correctly, a very good investment for a physician. And then the other thing people worry about is payer credentialing and contracting. Can I get in the networks? And so those are, I would say, some of the highest priority items that are at the start of the project.

David Mandell:

Yeah, that makes sense. I mean, I'm shaking my head the whole time here, but especially on the feasibility study. I think in certain areas, geographic, et

cetera, it may be pretty clear there's so much demand for this that people think I can skip that step, but I think that would probably be unwise regardless. Even if you're not in a saturated market, even if it's a growing city or something, to have that kind of study so it gives you some discipline around not just, and you can tell me if this is right, is it financially feasible, but some order of magnitude of what we can expect in year one and two and three and some growth rate so we can have the confidence or the conservative approach regarding things like office space and what have you.

Meaning in my mind, if I'm in a place where the demand is just incredible and I'm coming out and we see that in the feasibility study, well, I might be more confident to buy a place versus, yeah, you can make this work, you're going to have to get ... But it might be a step back before a step forward. It's probably better to rent to at least maybe do a short-term lease and see if we have our feet underneath each other on the practice before we go into a purchase. Do those things interact to some degree, the feasibility and the investment in the property or equipment or other things like that?

Teri Yates:

They do. Every project is unique. And there are some people that, to your point, they're in a really high demand area and they're doing quite an expansive project. I am probably by nature more conservative in part because I am a founder and I bootstrapped my business. I never borrowed any money from my own company until 2020 when the pandemic happened. Everything else was self-funded. And so, I tend to be conservative. And I always tell doctors a very conservative way to go about starting a new practice is phase one, phase two. Don't build your dream house for your first phase. Find a place that's relatively inexpensive, smaller, that you can lease, but not for 10 years, for a shorter time interval. Get some cashflow going. Assess how much the demand really is out there for your services and then build your dream house.

And look, not everybody does it that way and not everybody has to do it that way, but that's a very, to me, highly correlated with the physician's satisfaction with the startup is when they don't overspend on real estate. But it also removes that temptation in some respect to sign a 10-year lease if you're not saying, "This is it. I'm going to stay here forever," because a landlord will give you a big package to build out a lovely large space if you want that, but then they're going to want a 10-year lease. And so, if you're going in for a short-term lease, then it keeps your options open to then develop your own real estate, which is, again, financially quite lucrative.

David Mandell:

Yeah, totally makes sense. Kind of take it in stages as any business really would be doing. Okay. So that's just a couple of thoughts and some high-level insights on the new practice. Now, you certainly, I know this, work with a large number of established practices. So, give us some things there that are kind of like red flags or where you've seen practices not do well, because I think that's just as much important in this podcast as what we want to do well.

Teri Yates:

Yeah. Well, when it gets to the reasons that a private practice might fail financially, the first thing I have to say, and I'm humble about this and I understand that could change. And at some point, it will, given the number of businesses we've been involved in starting. But so far to date, none of the new medical practices that we've launched have failed financially. And that is in part because we are very diligent about the feasibility study. And a large percentage of the feasibility studies we do, the doctor decides afterward, "I'm not moving forward with the project," because they didn't really understand what it was going to take financially to do it. So, the people that move forward are committed because they're well-informed.

David Mandell:

I want to come back to that a second. I know you got a couple other points, but that's really, really interesting to me, but let's come back to that. Okay.

Teri Yates:

Sure. So, the things that cause private practices to struggle financially, because we come in and do assessments, right? People will call us in, and we do an assessment to see what's going on in the business because they want to make it better financially. And the common reasons that we see practices struggle are, one, the due diligence was not done in advance. And so oftentimes they're under capitalized at startup. Without that budget and Performa, they don't borrow enough money and then it gets very uncomfortable because there is quite a lag as you're building your revenue stream and you're building your accounts receivable. And so that can be really challenging, and particularly in instances where you've overbuilt on the office, you have a lot of high fixed costs, if you have high-cost expensive equipment. So, one is under capitalizing from the start can make it really tough.

The second is almost the opposite problem where doctors don't spend enough on the right things. And so, if you don't have qualified management personnel to help running the practice, that's another predictor of problems because physicians mostly do not get any training. They don't get any business training in medical school. And yet if you're a private practice owner, you are a small business owner. And so, you need to have a qualified administrator or at least a consultant or somebody advising you as a physician as you're learning the business of administration and running a business.

And then another big factor that predicts problems are owners that don't commit enough time to running the business. Businesses don't run themselves. And so, you've got to have enough time in your week to practice medicine, but you've got to carve out a few hours a week to manage the finances and manage people and do all of that administrative stuff as the owner.

Now on the success side, factors that predict success are, one, you've got to be a good doctor. If you're not a good doctor, you're probably not going to have the successful practice. But assuming that you're going to be a good doctor, we've talked about not spending too much at the front end, but the other thing is, is when you're just trying to run any business, you've got to have a relentless focus on data and analyzing what's happening in your business and holding people accountable. And I think if you focus on the data and you hold people accountable, you're likely to be successful.

David Mandell:

Yeah. We could do got a whole episode just on what you just talked about in three minutes here, but I want to come back first to that failing the feasibility study because I think a lot of people when they hear that said, "Oh, the feasibility study, that's like the first step, but it's always going to be like a go forward. It's always going to be a green light." And that's not really tied to the word feasibility because some things are feasible and some things are not, right?

Teri Yates:

Right.

David Mandell:

And I think it's a credit to your firm too, because obviously there's business to be done when a patient, excuse me, when a client, a doctor says, "I want to move forward." But you're giving them the honest assessment with the analysis that you guys do, I'm guessing. And sometimes it comes up a red light or a very significant yellow like, "Hey, warning sign, we're not saying you can't do it or you shouldn't, but you got to go. This is not like a no-brainer." So, you have, let me just ask the question I'm getting to, which is you have docs coming to you saying, "Hey, I'm thinking about doing a private practice." You're going through this feasibility study. And at the end of that, they're saying, "Based on this analysis, I'm not going to do that. I'm going to stay as an employee doc or look at another practice or do something different than launch a new practice." Is that right?

Teri Yates:

More than 50% of the projects that we do a feasibility study for, do not go forward.

Teri Yates:

It used to be probably 30% did not go forward, but as reimbursements have ratcheted down tighter, probably it's more 50/50. And sometimes that looks like it's not going to be profitable. Sometimes it just looks like it's not substantially more profitable than what I'm doing now.

David Mandell:

Right, right.

Teri Yates:

Sometimes it looks like I don't like how much capital I'm going to have to put up initially. There's a lot of different flavors of that. And sometimes it's ... So, here's an example. We got hired to do a feasibility study for someone and they were thinking about building an ambulatory surgery center, which is a wonderful asset for a physician in a lot of ways, but it's a big heavy lift financially. When we really went through all of the numbers, the doctor had to weigh the risks and benefits and it looked profitable, but that doctor also had an opportunity to invest in somebody else's existing ASC.

And it wasn't so wildly profitable that that felt like it was worth it compared to the lower risk investment opportunity they had. And that's okay. That's okay. Our fees to do a feasibility study are probably a 10th of what our consulting fees would be to start a new practice. So, you're right, we've got every incentive in the world to say do it because then we stand to potentially earn a lot more money. But our success over this last 12 years has been based on physicians telling their friends that Accountable is trustworthy. And so, for us, we would never be successful if we were earning money by hurting people.

David Mandell:

Yeah, yeah. No, I totally get it. And what that tells me also is, because I know this, that there are a lot of docs who are not doing that, who are skipping that step, or just saying, "Hey, I want to be my own boss," and go out and do the practice, et cetera. And that tells me that kind of explains why so many practices are getting into trouble financially because if 50% of the people are coming to you are doing it the right way and you're saying, "Well, it could be done, but it may be not be," like you said, for all the reasons, maybe you have an opportunity to invest as a passive rather than do it yourself. Maybe you have a ... It's better, but it's not that much better than what you're making already as a W-2, et cetera, and so it's not worth all the headache and all that.

What that tells me is if you don't do this, you might have a 50/50 shot of getting yourself in trouble because this isn't like, not even my brother, but my Father's Day where basically everybody who started a practice made money. I mean, that's 50 years ago now, 60 years ago. So, the other thing I want to point out is that sliding scale that you mentioned between being under capitalized. Now we're getting to you've moved forward and why doesn't it work well. Under capitalization to spending too much on the wrong stuff? So, it's not just a simple throw money at it answer because you could spend money on the wrong things, but it's also not a do it as cheap as possible answer. It really is, it takes more savvy, more wisdom, more experience, more expertise to figure out where you're going to be in that sliding scale and try to be on the efficient to frontier, as they say in the investment.

Teri Yates:

Yeah, you got to spend money on the right things. I mean, I had a client that we did consulting for in his startup, but he was very fixated on what billing services were going to cost. And he hired someone for billing, and I knew this was going to be a problem, but he got a very low percentage from them. And I talked to the guy about six months after he opened. He was a very busy interventional cardiologist, and he was sitting on his own on Friday afternoons calling insurance companies and haggling with them himself about claims that weren't paid. And I was like, "You could be generating so much more

revenue doing two more cases than you would be paying a better billing partner."

David Mandell:

Yeah, of course. Highest and best use we've talked about. That's been a huge theme for six years on this podcast. Delegation, surrounding yourself with experts. I mean, it's just like, I mean, I could give examples and examples, examples, right? People who want to do their own tax returns, people who want to go on LegalZoom and do that rather than hiring a lawyer, all that kind of stuff. So okay, I want to keep moving because you got a couple other important topics. So, in a practice that's ongoing, and a lot of docs listening to this are in practices that are ongoing. They're not a startup, but they're not looking to jump. They're in their own practice. How important is revenue cycle management? And I guess we were kind of talking about that right then, and where does that fit into a successful practice?

Teri Yates:

Well, I mean, it's fundamental. So, cash is king. If you don't have any margin, you don't have any mission. You can say it a bunch of different ways, but one of the things I learned when I started the consulting business, because at first, I was doing a lot of assessment and management consulting for improvements, and everybody had problems with billing. It was just a nuisance, whether you hired an outside company, whether your own people did it yourself. And look, that's what started me down the path of starting a billing company, which I did after I was out consulting for about three years.

I mean, I hate insurance companies. If you'd asked me 10 years ago, "Do you ever want to have a billing company?" I would've said, "No way." But it was a problem for everyone. And so, it's fundamental to the success of the practice. It's very poorly done and it's very poorly understood. And so, most doctors think about billing as being something that's handled by the people that work in one department or an outsourced vendor, but revenue cycle management is actually kind of a process. It's a relay, if you will, that requires active

participation from a lot of people, whether they're in your practice, in the clinic setting, at the hospital, in the billing department, it's all over the place.

And so, there's more than a dozen steps in the revenue cycle that have to be executed properly for you to get all the money. And it's challenging because I don't think a lot of physicians understand all of that and they don't necessarily know how to change it if one of those steps is not working the way it should. And it's really hard to understand it because the reports that doctors get, the billing reports aren't very instructive. For the most part, it's usually, this is how much you charged, these are the write-offs we took, this is how much you got paid. Maybe you get a list of individual procedures or services that you rendered, but most of the billing reports aren't that useful in terms of understanding why did I get paid that much this month?

So, we kind of think that the easiest way to teach anybody, whether it's a doctor or administrator or anyone about the revenue cycle is to put data into visualizations, the USA Today, the charts and the graphs, and we use advanced tools that are business intelligence tools. So, in our practice, it's Power BI where it's interactive. And so, when I look at those payments for the month, I can click into those and then the next layer is who all the insurance companies are. Or if I'm in my accounts receivable aging page and I look at all of the money that's sitting in my AR that's more than six months old, and I don't like the fact I haven't been paid, I can just click and see, "Well, who are the individual insurance companies?" And then I can click and drill deeper and see what are the reasons for these denials. And so that kind of interactive data visualization is what I think takes RCM out of the shrouded kind of mystery for physicians and helps them learn more about it so that people can make things better.

David Mandell:

Yeah. It's not an area I know a lot about, but I do agree with you that it seems to be something that almost every physician or practice complains about or feels like even if they feel like they're doing a decent job, they know there's

money left on the table. I don't think there's anybody that I've ever heard when they talk about this subject is like, "Oh yeah, we got that totally wired. We don't have any issues with that." And I think that's probably just the nature of the process. But yeah, going beyond the first layer, it sounds like it's crucial. You got to get a little more ... It gets back to what you said before, which is you got to understand if you can't ... There's that old saying, if you don't measure it, you can't manage it. And measure might be more than just that first layer, might be understanding that second layer of what's happening below the surface. So that part I can certainly follow you on.

So, let's talk about operational efficiency beyond revenue cycle. What about things related to staff? Again, I would say probably, and this isn't just with medicine, but staffing and people issues are probably the biggest challenge for most businesses, to be honest with you. I mean, and it's certainly universal for anything from our business to law firms I've been part of, et cetera. Every business, especially in service area, comes to people. And when it comes to people, it's not always so easy. So how do you guys help physicians and what do you see there as best practices?

Teri Yates:

Yeah, well, staffing is definitely the pain point, especially over the last couple of years. And look, we're facing healthcare worker shortages that are going to get worse before they get better. And so, this is an area I'm particularly passionate about because I do a lot of work around some of these things in my own consulting firm or my consulting practice. And so, there's one way that we help people is very tactical. I have a lot of open positions that need to be filled, and I don't have enough bandwidth to get it done. And so, we have an HR division that will help physicians just go recruit and hire people. That's fine and that's necessary. And we do a lot of that.

But what I'm really interested in is how to create the type of business that employees want to work for and they want to stay working for. And more importantly, that they're the kind of employees that you want to have working

for you. Because I see a lot of physicians who feel so behind the eight ball on staffing that they have low performers and they're afraid to fire them because they just don't have enough bodies, period. And so that's a race to the bottom. And so, I do a lot of work with physicians and coaching them on how to create the operating philosophy for their business that's going to encourage excellence and how to, again, they're not intuitively good managers sometimes of people. How to manage in a way that gets the most out of your employees and how to get important employees to work effectively with each other as a team because you can have a lot of individual stars, but if they don't play nicely with each other, you don't get the kind of traction in your business that you need to.

And so that's really important and that's the science of management that we like to help people with.

David Mandell:

Yeah. Yeah. I think we've had different people on this podcast over the years talk about this challenge. And I do like the fact that you folks help both on the immediate, "Hey, we got to hire somebody," but also the bigger picture, which is let's get the right people in the right seats and do that. And again, for a lot of physicians and even for folks in my business, not everyone is a good manager, not everybody is really going to ... They could maybe improve on the margins, but it's just not their nature. And frankly, they might need somebody to be the right hand to handle a lot of that while they go see patients and do some of the business decisions, and they can do the best they can as a HR type of person, but they're going to need help to figure it out.

Teri Yates:

Well, in prompting, not just delegation. Delegation is important, but also that person who sits next to them that whispers into the doctor's ear, "Remember to say these things to the employees," because here's the truth, the buck stops with me and my company, and if you're a physician who owns a practice, the buck stops with you. And the last thing I did right before I stepped in to record this podcast with you was something we do in my

company. We had two new employees who were starting their first day of work today, and the HR manager orders lunch for them. And I sat in on the lunch and we had lunch together. And it was very organic.

There's not a big PowerPoint presentation, but I chatted with these two people and found out a little bit about them and where they came from. And then I used that time to tell them a little bit about our work philosophy and that it's very important to me that the people who work here really enjoy their day because work is hard enough without making it harder. And what that really boils down to is in our company, we figured out that if we have mean girls or mean guys, everybody feels worse and productivity declines. And so that's important. I don't have a lot of time to do that. And I have other people who manage both of those employees every day, but me taking the time as the owner to say to them, "This is what I expect," is very powerful.

David Mandell:

Yeah, I'm glad you brought that up. I'm glad we recorded the podcast today because then you have that story fresh. We didn't know that was going to happen, but I think that's probably the kind of thing that many physicians who have poor partners in a practice should be doing and aren't. They're saying, "Yeah, I pushed that off to someone else. I say hi in the hallway and I might just shake their hand when they first show up first day, but I'm not spending that extra time to get to know them." A, but also to really have it come down from the head person, what the philosophy and what the approach is here. This is how we do things here and you want to hear from the person whose name is on the door type thing.

Teri Yates:

Right, exactly. Now, if that employee does something that does not fit with the philosophy, it's not the physician's job to go do the discipline. Your practice administrator does that. However, you have made it clear what the expectations are and now empowered the practice administrator to hold that individual accountable to your philosophy for how your business should be run.

David Mandell:

Yeah. Yeah. Excellent. Yeah, I'm glad you brought that up. That's a really good example and real world. And for my last question, I want to change this. We've been talking really micro practice level. Now let's go macro. What's going on in the world, in the world of healthcare? So obviously we all know this. More and more physician employment. We've seen this in our careers working with docs. And in the beginning of OJM and when I was an attorney, most were private practice physicians. And now I don't know the exact percentage in our world, but there's a lot more employed docs and that seems to be what's been going on all across the country.

So, yet you've built your business around private practice, and we love private practice because we can do some things, help them with their qualified plan, help them with their corporate structure, their taxation, et cetera, that we can't do for employee docs. We love our employee docs too, but it's just a different level of work we can help them with. So, what's your outlook on the future of private practice? Where do you see things today and that we start in 2026 and in the near future?

Teri Yates:

Well, there are a lot of people opining that private practice is dying, and I don't believe that. Obviously, I don't believe that because this is what I've chosen to do for my life's work for more than a decade. We get more than a dozen inquiries every year for people thinking about starting a new private practice. So, people still want to go into private practice. And usually the driver, like I said, is autonomy. It's not about money. Money matters. It has to be a good financial decision, but generally what drives people to private practice is the desire to control their environment, to choose who their employees are, all of those things.

I think it's actually vital to the health of our healthcare system for us to have a thriving community of physicians and independent practice because frankly, outpatient settings are more efficient. When physicians work in the hospital,

everything happens more slowly and less efficiently. And that's a problem because demographic trends are showing that we are going to have increasingly severe shortages of physicians. It's going to be worse in certain specialties, but this is an issue. The population is aging. There are not enough physicians coming out of training to keep up with what's needed.

And so, we got a big lift using physician extenders. That was one thing that really expanded physician capacity, but we've got to do things more efficiently. And so, I work with a lot of surgeons and if they're doing their cases in an office space surgery suite or an ambulatory surgery center, it literally often means I can do six operations today instead of four. And that's what the healthcare system needs, both from a cost perspective, but also just so that we have enough physicians to care for everybody who needs it. And obviously, if you have good ancillaries, which is a crucial part of physician income in private practice, you can make a lot more money statistically speaking than you do when you're employed. So, I'm actually quite optimistic that private practice is going to continue to be a very important part of our healthcare system.

David Mandell:

I think as long as the interest is there being autonomous, which is I think most physicians just by their nature are autonomous. And certainly, they go to med school and most training, and that encourages that. Everybody thinks they're on their own and it's kind of an individualized profession. With what you also described is a higher demand. That means that physicians should have some power in that if people need them. So, if they want to be out in private practice. Now again, that's fighting against consolidation, that's fighting against hospitals, that's fighting against maybe some of the economics. But I hope that you are right. I think so also. Listen, my brother's a solo cardiologist and there aren't many of those around, but he's-

Teri Yates:

No, there aren't.

David Mandell:

For a long time. And why? He likes being his own boss. And I'm sure he knows in some ways that there's some things that he could be doing if he was with a group that he can't do personally, but at this point that's been worth it for him. So hopefully there's more of that to come.

Teri, I really appreciate you being on really some ... I learned a bunch and I'm sure the people listening and watching. We will, again, in the show notes, make sure we have Teri's website and a way to get a hold of her. So, if you want to talk to her about your existing practice, your thoughts about a new practice and that feasibility study, which I think is so important, you'll have a way to do that. So, thanks, Teri, for being on the program.

Teri Yates:

Thank you very much for having me. It's been a pleasure.

David Mandell:

And for everybody watching and listening again in another two weeks, we'll have another episode. If you're a physician who has something interesting to say, feel free to reach out. Would love to have you on. And if you feel so inclined, give us a five-star review, a rating on the exchanges and the platforms, and tell all your colleagues about us. And with that, we will conclude and we'll see you in another two weeks.