Changing Medicine Starts with Creating Your Voice with Vinod Dasa, MD.

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[00:00:08] Hi, everybody, and welcome to another episode of the Patient Convert podcast. Really excited to have you listening today. It'll just be your cohost, Justin not, and I'm really excited about our orthopedic surgeon guests. Dr. Vinod Dossa, Dr. Dossa, thank you for joining us and to get started. Why don't you tell us a little bit about yourself, your background, all those type of good things?

[00:00:31] Yeah, sure. Thanks for having me. So I'm an orthopedic surgeon. I'm in New Orleans. I'm at LSU Health here in New Orleans, but I do the bulk of my clinical practice and a large health system here called Honor. I did my training up in New York, did my medical school up in Albany and then my residency in Buffalo. And then I did my fellowship with the InSAR Scott Kelly Institute in Manhattan, which is basically one of the pioneering practices for knee replacement. And then I got recruited to come down in

New Orleans back in two thousand seven post-Katrina. So as you can imagine, the city was devastated. The LSU Department of Orthopedics was struggling. And so I got recruited to come down here to kind of rebuild to the best I could the department. And so I spent the first few years just kind of figuring out what's what coming right out of fellowship and training. You're just trying to get your feet under you and get your practice up and running. And as you can imagine, New Orleans back then, you know, there were no streetcars. There were blue tarps everywhere. I mean, barely a grocery store was open, so it was interesting times back then. I think, for me, very informative because I got asked to do a lot of things that I otherwise wouldn't have done because there's no one else to ask. So I was getting involved in meetings and getting involved in projects that I doubt I would have ever seen otherwise. And so, you know, fast forward helped rebuild a lot of our research infrastructure and clinical practice, things like that. And here we are today.

[00:01:53] Well, and that had to have been fun at that time, too, because like you said, I mean, getting to wear that many hats and getting to do things versus just kind of walking into kind of a regular gig as a general ortho at a hospital, you're going to do these couple of things day in and day out and getting thrown into a situation like that during something chaos, chaotic and in a real rebuild scenario. I'm sure it was a lot of fun getting to wear that many hats and where you are today because of it and all the knowledge that you gained.

[00:02:20] Yeah. So I mean, like you said, I think I got experiences that would have otherwise taken me 10 15 years to get within my first three or four years there. So it's been really interesting to see how health care functions and how to get involved at different stages, but more on a fast track pace that I was on.

[00:02:38] Excellent. So I've got to jump right into it. Once we had booked a podcast out, I was doing a little bit of research on you and your background, and something really jumped out at me on the knee replacement side that you are doing a lot of opioid free knee replacements, which is a little mind boggling to me. So I wanted to ask about what is that? How do you keep the pain under control? And obviously with the opioid epidemic that is hitting America, I mean, why you wanted to make sure that that is becoming a reality, which sounds really incredible for patients?

[00:03:13] Yeah. So we've made tremendous progress over however many years, probably over the last 10 years, but really over the last five years, you've seen this really huge, monumental shift in how we perform orthopedic surgeries and pain control, especially knee replacement, right? And so one of the big changes was our shift from general anesthesia to spinal anesthesia and then a recognition about regional nerve blocks. And then we started a thermal nerve and we now move closer down to the knee to the adductor canal block. And if you notice we did a tremendous job managing pain during the hospital, stay right? I mean, we're now we were doing outpatient surgery. So that means patients have a pretty good pain control so they don't need to stay in the hospital anymore. So we were doing a pretty good job of managing pain within the four walls of the hospital. But I realized, you know, once the patient hit the parking lot, it was kind of like, you know, good luck, right? Wheel them down, put them in their car and off they go and it's crickets. There's no help. There's no innovation. There's no nothing in the postdischarge space. And so I started working on some technology where you could freeze the nerves around the knee about a week before the surgery. And the new technology is called Kuvira. And we started using that technology back in twenty fourteen. And just, you know, I had treated patients with knee arthritis with freezing the nerves around the knee and they were getting tremendous relief.

[00:04:34] And so I thought to myself, Hey, you know what, if we applied this in the surgical space, that may be a big deal. It may move the needle. And we went ahead and started treating and freezing those nerves about a week before surgery. Then lo and behold, we did a research study to see how those patients did, and I reduced my narcotic prescriptions by almost forty five percent. Wow, that's amazing. Then, yeah. So then, you know, as with most things right, you keep iterating and you try to keep improving and improving. And we had a long acting nerve block called ex-pro was. Approved by the FDA for shoulder nerve blocks, so we started using it around the knee. Granted, it was off label, but I felt clinically that was the right thing for my patients. Changed a few other things and then what I started realizing is I was talking to my patients after about, you know, maybe two years or so of enhancing our protocols and tweaking and then doing things. And I started asking my patients in the office, You know, how's your pain? And my pain is great. I say, OK, so how many pain meds are you taking? Well, I took all of them. I'm like, Wait a minute, so your pain is really good.

[00:05:37] But why are you taking pain medicine? They're like, Well, because you gave it to me like, wait. But on the bottle, it says as needed. They're like, Well, then why did you give it to me? So I went into you. I'm sorry, have these kind of very circular conversations with my patients, especially the older ones, right? Because you're the doctor, you gave me a bottle with stuff in it. I'm supposed to take it period, right? So I started, you know, paying a little more attention to my patients post-operatively. And a lot of them would say either no one, they actually listen to me and it said as needed. So they didn't take it or they took very few of them. Or, like I said, I had some of the patients I've just taken because I gave it to them and I started realizing, Wait, a lot of these patients aren't using the pain medicine I'm giving, giving them. So I started backing off on my narcotic prescriptions and backing off, backing off, backing off. And then COVID hit. And so what was that March of twenty twenty? And at that point, I'd seen enough of these patients where I'm like, Whoa, hardly anyone's taking anything, but I didn't have the guts to kind of go cold turkey. And I started emailed all the nurses and therapists at the hospital because usually I like to do these things as a team.

[00:06:40] I don't like just putting an edict out because there's stuff I may not realize or know or there, you know? So it's really it's a team effort where I am at Osher. And so I emailed them and I said, You know, I'm thinking about doing this. This is what I'm noticing in the office after surgery. And they're like, Well, maybe, you know, and so we're kind of bouncing around ideas. Covid hits. So obviously everything stopped. And I thought, this is a cool opportunity to kind of hit the reset button, right? Because when we come back, you know, we had six weeks off or whatever it was like, this is kind of a nice kind of line in the sand where I could come back and maybe really change. So COVID comes back and I told everybody, Hey, when we come back, I think we can go opiate free. You know, we've got all of this in place. We have enough experience here. And obviously, if the patients are struggling afterwards, I can prescribe it. Pain, meds and narcotics. Let's see how this goes. And so we came back, was it mid-May of twenty twenty and we went opiate free. So all the patients got after surgery was Tylenol and NSAID. So diclofenac. And so we started doing it. The world kept turning. The sky didn't fall. Patients are doing well and no one was the wiser.

[00:07:43] And so we just kept doing it. And then we pulled our data. So this past March with because I wanted minimum 90 days after surgery and we look to see how we did, we looked our pain and function scores, and I look to see how many patients took

narcotics after surgery. Because here in Louisiana, I think a lot of states it's now centralized opioid prescriptions. The State Pharmacy Board captures all of that, and we have a dashboard so I can look up every one of my patients and see if they received any opiates anywhere in the state. And actually, they've got networks with other states, so you can actually see in the whole region if anyone got opiates. So it's a great tool for physicians to use. Actually, we're supposed to be using it on all our patients. And so we pulled all the opiate data. And what we found is we looked at the first 40 patients, eight of which were on opiates going into surgery. So thirty two were opiate naive going into surgery. So if we look at just those thirty two patients opiate naive going into their knee replacement. Eighty five percent were completely opiate free 90 days after surgery. Wow, that was incredible. So all they took was Tylenol and then said, And so that now has continued. So that's been locked in and it's now our expectation. It's normal for us.

[00:08:50] And the key component of that, though, is, yeah, you're withholding opiates. But is there pain through the roof now you're just withholding opiates? And the answer is no. So because we capture all of those scores, right, coup scores and promise scores and pain scores. And so the patients are doing just as well and have no opiates on board. So we're able to achieve what I think everyone has hoping to get, which is reduction in pain, enhanced pain control, enhanced recovery without the needs for opiates in narcotics. And so, so yeah. So it's been a great, great clinical experience. I think the patients appreciate it. I think we're doing hopefully our part in terms of dealing with the epidemic and trying to find hopefully a path forward that we can hopefully share with the rest of the medical community and really find it's there. We just have to go find them. Whatever you do, whether it's chest or belly or whatever, you know, there is a path to get here because if you can do it for knee replacements, I promise you, there's a pretty good chance you can do it for just about anything because arguably within all of health care, we were probably one of the most painful surgeries in medicine is knee replacement surgery. So if we can figure it out for this, then really we should be able to do it in a lot of other areas too.

[00:10:00] Now being, as you mentioned, kind of a year and a half since you hit that reset button, you've got this data. Are you helping other colleagues across the country implement this that are doing these surgeries? Have you been working with anybody else to try to get them to that 85 percent mark like you're at?

[00:10:18] Yeah. So, you know, obviously it requires a lot of innovations and it requires a lot of things. And so, you know, there are we're talking about it, you're giving lectures, people email me about it and social media and all that kind of stuff. So yeah, but it's a heavy lift to move the needle at this level. So there are companies and industry that I'm working with to help kind of get that out there. Get this information out there. There are other surgeons that are doing similar things. Maybe not zero opiates, but awfully close. And so, yeah, so it's a team effort and we're trying to get the word out to teach how other surgeons can get there. The challenge, though, is the system doesn't reward it, right? And so if you look at the way health care incentivizes us, if you eliminate opiates and do all the hard work, there's no incentive, right? Not that we're all hoping and wanting our patients to take opiates. But you know, if the system doesn't incentivize it, then and you've got competing things that you're trying to get done, you're going to get done, the stuff that you're incentivized to get done right because we only have a limited amount of time and bandwidth and resources. And so that's the case, then yeah, it's important we'll get to it, but just not today, because I've got these other three things I need to get done. And so that's the inertia, and that's the challenge. We all know it's important. It's just, you know, can we get employers and government and insurance companies and everyone to kind of say, Hey, you know, this is important, we are going to now incentivize you to go in this direction and until that happens, it's just going to be a heavy lift. Yeah.

[00:11:44] And that makes a lot of sense to me because if you've got an orthopedic surgeon looking at all of the priority things and as you mentioned, the incentivization things to to get done over the next six months to a year, why put this at the top of the docket outside of kind of wanting to go down the Good Samaritan route? It's like, Well, you've got this easy pathway of rights in narcotics, post surgery, you know, the patient's going to do fine. You don't have to take a risk of them being in high pain or any of that. So it's just like path of least resistance. I'll handle the stuff. I mean, they're incentivized to do or that is going to be easier to do and not go the route of implementing something like this, right?

[00:12:21] Yeah. I mean, it requires a fundamental change in culture that this is what you want to do, you know? And so the question then is why?

[00:12:28] And that makes a lot of sense now. I would assume because you do sports medicine as well, you're obviously at LSU, which is one of the top football programs and just collegiate programs that's out there in the SEC is this model. Does it really matter between, say, collegiate and pro level athletes trying to get back out because you see a lot of them, like Russell Wilson, having to get pins, put in his fingers or whatever it is. But that model still kind of followed on the high level athletic side, as it is for a normal Joe Schmo that's 55 or 60 and has to get a knee replacement.

[00:12:58] Yeah. So, you know, the concept of enhanced recovery after surgery is not limited to a 70 year old getting a knee replacement, and this concept's been there forever for general surgery and abdominal surgery and all that kind of stuff. So these enhanced recovery protocols apply to elite athletes as they do know your grandmother. And so, you know, things like Oliveira, there is. So there's a growing interest potentially in using it for ACL reconstruction and enhancing recoveries after that. And a lot of other areas. One of the biggest fears, though, is making the joint in Sense8, where if you numb it up, are you going to lose the protective sensation, right? And things like that. And the answer is no, because the nerves that we're blocking are really more geared towards certain aspects of the knee, for example, compared to other nerves. And so you don't lose the protective sensation of pain or reception because there are other nerves handling that. So we're just targeting the key nerves for specific types of pain. And so, yeah, so there's a lot of interest in scaling this, these technologies across other areas, shoulder and rib fractures, for example, can you go after some of the nerves around the rib fractures? So it's not as painful things like that? So yeah, there's a lot of growth here. It's relatively young and new technology, as is some of these other protocols. So I think the, you know, the future is bright. You know, there's a lot of opportunity here.

[00:14:17] Oh, that's fantastic. Switching gears a little because this kind of leads us down kind of a marketing path, which is what we talk a lot about on the podcast. You're involved in a lot of stuff just outside of the clinical practice side, kind of wearing multiple entrepreneurial hats. So I'd love to talk a little bit about. I know there's a lot of surgeons either that are early on in their career, maybe further down and have one to diversify and be involved in. Maybe some business adventures, those things and become an entrepreneur, and either they are not sure how to get started or probably feel a little overwhelmed. Like, how do I take on that much more stuff on my plate, right? Tell me a

little bit. Hey, what are you involved in and what are you doing? But how did you get in there and what type of advice for authors or just busy physicians out there in general that maybe want to diversify? Find their career outside of the clinical practice.

[00:15:08] Yeah, honestly, I think physicians really need to diversify themselves outside the clinical practice. I mean, health care is changing. You're running faster on the hamster wheel. And so the end game doesn't look pretty. So I think physicians actually have to look and broaden their skill set beyond just the exam room or the O.R.. And if you think about it, physicians are in a very unique position. They can leverage a number of different assets to their benefit. So it could be as simply as, you know, how do you take your medical license and leverage it well beyond just seeing a patient right? And the other thing to think about is physicians represent a low risk category, whether it's going to the bank or funding or things like that. And so, you know, all your local banks, they're going to be willing to fund you, right? You're not going to have to jump through a number of hoops as some sketchy person down the street because you're in a low risk category. So if you're looking to diversify, it can be done in a bunch of different ways that doesn't involve running faster on the hamster wheel. It could be not that I'm a real estate mogul. I mean, but it could be, you know, it could be even as simple as real estate. You know, a lot of physicians do invest in real estate and get in those angles.

[00:16:18] I think from an industry perspective, there are a number of companies startups looking for help, looking for advisors and clinical acumen to guide them in the right direction. But I think you have to be a known quantity. You need to get out there. You can't just be hiding under a rock in your practice somewhere. You know, you could even as easily talk to you if you're an orthopedics and you work with implant and device reps or even pharmaceutical reps. They are a great resource, I think, for physicians to get plugged in. They know they have a pulse on the industry. They know potentially if their company is looking for help. Or it could be like, say, a ninety nine rep who's constantly getting new technologies brought in that they want to put in their bag. They have their pulse on what's coming out right, and you may even want to talk to them and say, Hey, can you help me find some new technologies or new young companies that are looking for clinical advisors or clinical help and they can get the word out? So I think physicians really need to leverage all the relationships, just like everyone leverages their relationship with us to get us to prescribe more things or right for more things. Or

do this or do that right because we control the health care dollar with our pen and with our scalpel.

[00:17:25] Likewise, I think we can reverse that, leverage those relationships in the reverse way and talk to those people and say, Hey, what opportunities are out there where, you know, hopefully the rep or somebody knows you and they know your skill set and they know your personality, can you go out there and help me go find some new opportunities in health care? So I think you have to be creative. You got to be innovative, but you have to be a known quantity. You have to be out there so people know that, hey, you, you have something to bring to the table, right? And I think social media is a great way to do that, to build your brand, to get your name out there. So people say, Hey, I like the way that person thinks or they're really posting some interesting things or that's a novel idea, you know, can we get them on board with our company or with our product that we're working on? I think we do a very poor job collectively as physicians of really telling people who we are, how we think, why we think so that way when a new company is born or they're looking to write some new health policy right at the legislative level or whatever it is, people don't realize that they need to talk to us.

[00:18:28] Yeah, that's a great point. And that is something I definitely want to talk to. I mean, obviously, even the reason that you're on the podcast is your activity on LinkedIn, and I think you connected with my wife and the other agency owner in our podcast, co-host Kelly. What are you doing from a thought leadership development standpoint? You're very active on LinkedIn, you're obviously on this podcast and we're doing video too. And that's something that we preach a lot to physicians as you really need to focus and not forget about your personal brand because that's really what's going to take you. Whether it's about building colleague relationships, whether it's building business relationships or it's building direct to patient relationships as the expert in your field. It all starts with whether it's getting in front of the camera or getting in front of the microphone, or getting in front of a pen to paper writing blogs. But you've got to choose the meeting, you've got to get out there. So what's been your mediums of choice and what's your advice you have on building your thought leadership?

[00:19:24] So I think there are different platforms based on what you're looking to accomplish, right? And so I think Facebook and Twitter and those kinds of things are

looking for a broad audience probably driving patients inside that kind of stuff, right? So if you're looking to be busier, that's great. But you know, I'm of the mindset of working smarter, not harder. And so running faster on the hamster wheel and loading my practice up with 20 percent more patients so I can run faster on the hamster wheel. To me, that's not a smart use of your time, right? Because you've got a lot of expertise, you've got a lot of know how built into what you've accomplished. So say you're been in practice 10 years, so seeing three more patients doesn't leverage that to its maximum, right? So then you've got other platforms like LinkedIn, for example, that are more professional, where you can take that experience and leverage it to your advantage, right? Get out there and let people know that you've got something to offer besides doing another knee injection or shoulder injection, right? We know that, but that doesn't help our company or help our health system or help whatever kind of think bigger. And so, you know, I think physicians need to start and we've been trained to be humble, right? Just keep quiet.

[00:20:35] Go to the office. Do your thing. Don't make waves and just go, which is fine. And there are some people that's all they want to do, right? And so if it's not and if that's who you are, then great, then I think maybe do a little bit on Facebook or something like that, drive patients in and do your clinical thing. But if you want more of a sustainable, I think, path forward, then I think you need to kind of start thinking broader. And if you're an endocrinologist and you have some ideas around diabetes or obesity or what have you like, why are you holding that into yourself? Why is it just on a notebook on your desk? Who's going to learn about that? Who can hear about that, right? And so that's why I think the digital platforms are huge for physicians to create a voice and create an identity because it's been beaten in our heads to just mind your own business, put the blinders on and just move forward. And I think that that's been to our detriment, and I think we learned that in medical school and we've got to unlearn some of that stuff and realize we have a voice and we have a seat at the table. We just were taught not to take advantage of it.

[00:21:34] Yeah, I couldn't agree more. And it seems like to me what we tell physicians a lot too, is two things and I'd love your opinion on them is really, you've got to start somewhere. I think the physicians get overwhelmed by thinking about like, well, what camera equipment do I need like this and that and the other. And it's like, start. That's the best place, especially as a busy surgeon is to start and to just like you're doing,

taking time out of all of the different things you have is you've got to be deliberate about it, like it's got to become part of your normal process on a monthly basis. Whether it's specific, carve time out or just being deliberate about getting it on your schedule throughout the month. But I mean, what do you think about? Because that's really what we talk about is you got to just get started and you got to be deliberate,

[00:22:16] You know, and people are looking for sincerity. They want you to be genuine. You know, it's not about the camera and the light that you got. It's about what you have to say, you know, I mean, are you putting something? I mean, you just saying, Hey, look, that baby elephant wasn't that great getting pushed up to the hill or whatever. That's not what it's like. What are your thoughts on health care? And you're so knowledgeable on it. We want to hear you right and so absolutely rarely hear from physicians. There's so few voices out there. It's not hard to get your voice out there. The noise is not that bad as it comes to physicians talking. So it's a very light lift, just simply, you know, and start easy. Just say, Hey, what do you think about the opioid epidemic? I mean, it's something that is important where a physician's voice should be heard and put it out there, right? And then slowly kind of dip your toe in the water. And trust me, LinkedIn doesn't bite. You know, no one's going to come and, you know, punch you in the head or anything. So you know, you dip your toe in the water and you get used to it and like, Oh wow, there are people that liked what I said and it resonated. And then you go a little further and little further and little further. And then all of a sudden, now you look back and like, Holy cow, you know, people are listening to what I'm saying. This is crazy. It's not just one patient in an exam room, it's a lot of people that think what I'm saying is important. So I have the ability maybe to move the needle and then it gets really, really fun and really interesting at that point.

[00:23:39] Yeah, for sure does. And I think what you said too, is interesting because the rawness side and if you just look at all of the social platforms as a whole, as you look at what LinkedIn's been doing over the last year and a half or so rolling out LinkedIn Live, they've got stories now. You've got Facebook Live, Facebook Stories, Instagram, IGTV, Instagram Stories. All of that stuff is really predicated on rawness and live and user generated content and most of the content you see on those platforms and the most reach on those platforms because they want tool adoption, they want people using those tools is going to be by using your phone and creating real on the spot content, and that's what 80 percent of what you see on platforms anyway. So I think that that's

what consumers, patients, colleagues associate with good quality content now because it doesn't need to be a big production. It's really about the, like you said, standing behind the material and the quality of that material as far as what's being said in the videos and not the production that's behind them.

[00:24:43] Yeah, absolutely. And you know, just as I do, there's a lot of fluff out there, right? And it's just manufactured stuff and it doesn't resonate with you. You're like, Yeah, yeah, yeah, right. But then when you find those posts that are, like, legitimately real, it's an issue. It connects with you, like, OK, I like what they're saying, that people can read through the BS. It's not that hard. So how do you differentiate you? Decent. That's it, it's not that hard, it's not that complicated

[00:25:09] And collaborate, I think especially early on, colleagues want to help colleagues and they want to help them get their story out to. And there's plenty of people out there like yourself that have been doing it for a while that I'm sure are more than happy to help other physicians that have a story to tell it, and it benefits both sides. I mean, you get in front of their network and vice versa. And so there's a lot of people that have established networks out there, especially physicians that have been early adopters to the thought leadership concept that are going to be more than willing to help you, as well as get accelerated lift while you're trying to get started and in content creation.

[00:25:43] Yeah. And you know, and I think physicians, we complain, right? The system is bogging us down. We don't like the system. It's not fair this and that and the other. The problem is is we don't say it like, you know, we complain, but no one gets to hear why. Right. So collectively, we all need to get out there and tell everybody why health care needs to be this way versus this way. And so it's incumbent upon all of us physicians to be out there explaining our story so the constituents can hear it. Whether it's a mechanic, a pilot, legislator, a health care executive, they need to hear the why of why we think health care needs to be fixed. And so then you create your voice and then you can see change and make your practice better and and do the things that we want to do.

[00:26:30] Yeah, I could not agree more. So before we wrap up going back actually to the entrepreneurs side, tell me a little bit about because you've got more than one

company that you're involved in specifically. So I love the listeners before we wrap up to kind of know about those and obviously different ways that they can get a hold of you and even in particular orthopedics out there that may want to know more about the opioid free approach. You have the knee surgery. I want to be able to get them in front of you, too.

[00:26:57] Yeah. So the two one is called Site Medical, so it's a technology platform that we developed to help essentially digitize their data by a surgical technique. So the sales reps, our surgical techs can learn a surgical procedure, use it during surgery, learn new techniques and things like that in a scalable way. And then we also help manage inventory implants and things like that. And so that's been going well. The next one is something called Doc Social, so it's a new online platform that basically connects all health care stakeholders. If you think about it, most of the stakeholders in the health care kind of live in silos, right? Physicians over here, nurses over their therapists are over here. We kind of coalesce and come together around a singular patient. But then we go back into our corners when it's not involving a patient. And none of us really appreciate how each other thinks or why we think how we think. But yet all the decision making in health care slowly becoming a team sport. And so it's not just me running into the CEO's office, thumping my chest, saying, I want this, it's nurses and therapists and pharmacy and everyone saying, Yeah, committee is that committee saying, let's go ahead and get this done? So we created a new platform to allow all health care professionals to learn, teach and collaborate with each other. And so that's called docs social. And so those are the two time consuming ventures I've been working on most recently, and it's been going very well. Can't complain.

[00:28:14] Excellent. We'll make sure we get those up in the show notes, so people can find out more about them. And then for the authors out there and really, because this is going to lead back to getting kind of in touch with you, obviously you're active on LinkedIn, but there's authors out there that want to learn more about this process that you're implementing on the opioid free side or really just listeners out there, they'd like to get in touch with you. What's the best way to go about doing that?

[00:28:35] Yeah. So the two easiest ways are number one, LinkedIn. You can connect with me and message me there. And then on Doc Social, so Doc Social, you can join that and connect with me on there. We've actually got content there. There's a group

called opiate sparing orthopedic surgery, where you can learn what people are doing to limit it, opiates and all that kind of stuff. So a lot of great resources.

[00:28:55] Excellent. Excellent. Again, we'll get all of that stuff in the show notes as well for all the listeners out there, so you can easily get a hold of Dr. Dossa. And, well, Dr. Dossa, thank you again. So much for taking some time out of your busy schedule to share a little bit of your story and give a little bit of advice to the listeners, especially the surgeons out there that are trying to grow their careers and everything that you're doing to advance medicine. So I really appreciate it.

[00:29:19] No problem. Thanks for the invite. Absolutely.

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