Ruth Adewuya, MD (host):

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I am your host, Dr. Ruth Adewuya. This episode is part of our Hot Topics mini-series. Dr. Michael Gisondi is the inaugural Vice Chair of Education in the Department of Emergency Medicine at Stanford University. He's a medical education researcher and an expert in the application of social media in medical education. He's a member of the editorial boards of Academic Life in Emergency Medicine, International Clinicians Educators Blog.

Dr. Gisondi is the recipient of numerous teaching awards, including the National Faculty Teaching Award of the American College of Emergency Physicians, and the Hal Jayne Excellence in Education Award of the Society for Academic Emergency Medicine. Last but certainly not least, Dr. Gisondi teaches a freshman undergraduate course called, "Does Social Media Make Better Physicians?" So, who better to chat with about social media? Thanks for chatting with me today.

Michael Gisondi, MD (guest speaker):

Oh, thanks for having me. I'm really excited to be on the show.

Ruth Adewuya, MD (host):

The definition of social media is very broad and constantly evolving. In the context of our conversation, when I'm referring to social media, I'm primarily referring to social networking sites like Facebook, Twitter, Instagram, and professional sites like LinkedIn and Doximity. Are there other sites that you feel clinicians are on and should be part of this definition?

Michael Gisondi, MD (guest speaker):

I use a pretty broad definition of social media. I define it as an intermediated tool, and it allows you to create and share ideas, or information, or interests in virtual communities of practice, or as you say, networks. So by my definition, this podcast is actually social media, right? Users can comment about episodes and you can respond, so there's a social nature to it. And you certainly have a virtual community of regular listeners to the podcast. So the social aspects of podcasts, blog sites and other digital media, it doesn't need to be as robust as Facebook or Twitter. So that said, I think clinicians may use a lot of social media, medical podcasts as an example, that they don't view as traditional social media.

But to answer your question more specifically, I think in addition to the sites you mentioned, physician influencers and educators are finding their way to TikTok more regularly, because young people view TikTok frequently, and they're the target audience for many public health and health education initiatives.

So much of the efforts of physicians is to debunk health misinformation on TikTok that's spread by non-health care influencers. Take for instance, Dr. Sandra Lee. She's Dr. Pimple Popper on television. She's on TikTok, and she teaches teens to care for their skin properly, refuting a lot of celebrities who promote harmful skincare regimens.

Ruth Adewuya, MD (host):

Data shows us that participation in social media by the general public has sharply increased over the past nine years. And in preparing for this conversation, I ran across a survey by QuantiaMD, where they surveyed more than 4,000 physicians and found that more than 90% of physicians use some form of social media for personal activities, whereas only 65% use these sites for professional reasons. From your perspective, what's the driving force behind clinicians' increased use of social media for professional reasons?

Michael Gisondi, MD (guest speaker):

It's a powerful tool, social media, in all the different platforms, simply different tools in your toolbox, when you choose a tool based on the task that you need to do. For instance, if you're going to hammer a nail into a wall, you wouldn't choose a screwdriver, right? So each of the sites has their own reason for existing and can be used in different professional ways.

There's a lot of different reasons, then, that physicians choose to engage on these sites for professional reasons. Just to name a few: public health initiatives, combating health misinformation, advocacy work for social justice or health equity. Of course, I'm a medical educator: medical education, knowledge translation for research findings, professional brand development. So there's a lot of different reasons, and you might choose different social media sites based on what your reason is.

I do think we should talk about professional branding a bit, because that's a reason that physicians are going to, particularly Twitter, amongst the social media sites, and perhaps reluctantly, told that they should do it. And other people are doing it, and they want to improve their professional brand. But it can be helpful to a physician's national reputation when we think about that for professorial promotion.

And it also can lead to opportunities that they may not have gotten if they weren't visible online, and I can give examples. I've been invited to lecture at several international conferences, by colleagues in other countries, who I first interacted with on social media. We became social media friends over the years, and then eventually got an invitation to speak in their countries. I would never have had those opportunities had I not been online.

But I think of all the reasons that physicians should be online, knowledge translation in the digital era is especially important. I teach a freshman undergrad class called "Does Social Media Make Better Physicians?" We study this phenomenon of knowledge translation throughout the course, and there's pedagogy related to knowledge translation online that's still poorly defined.

Take for instance, March 2020, when New York City physicians took to Twitter to post images of chest radiographs of patients with COVID pneumonia. So instantly, every one of us on Twitter knew what COVID pneumonia looked like, and we were also able to learn about low oxygen saturations that were tolerable, proning patients, things like that.

And then consider how long it would have taken to disseminate that same scientific information without social media. Maybe you would've gone to the next national conference of some relevant professional society, but that wouldn't be teaching physicians to a national scale, or it may take many months to publish a manuscript. And we learn from Twitter instantly. Pedagogically, there's something there. I would think that the more physicians interact and engage on social media platforms, the more powerful these tools become.

Ruth Adewuya, MD (host):

And first of all, it's such a great example, and thank you for sharing that, because following the thread, if it wasn't on social media, it was a time where we weren't traveling. There were no national conferences per se. It was really the appropriate tool at the time.

Tapping into your medical educator and medical education research side, how do you think medical learning has changed with the onset of social media? And do you think medical curriculums have adjusted well to teach in this age of social media?

Michael Gisondi, MD (guest speaker):

I love this question. Thank you for talking about medical education. You have two questions there. So first, 1000% yes, digital and social media are transforming medical education. Textbooks are being supplanted by medical blogs and medical podcasts that are more reliable, trustworthy, and I'd say comprehensive by the day. That's what we used to worry about. Were they reliable? Were these sites trustworthy? Did they only cover a little sliver of medicine, and not really the totality of a specialty or a discipline? I think we're getting there, and I think the longer and older these blogs and podcasts become, the more content that they're able to deliver.

The paper I wrote a couple years ago with my colleagues, we described what we call opportunistic learning. It's this idea that trainees are listening to medical podcasts in particular, at opportune times, in ways that their faculty members never did, so at the gym, on a run, in the car. When I was a resident, I wasn't listening to medical podcasts. They didn't exist. So I would just go to the gym. But now, you see everyone with their headphones in, and they're listening to podcasts and they're learning, and they're taking advantage of time that wasn't previously afforded to us, that lost time to learn.

I think similarly, when they're in the clinical space, they're using digital content, like up to date, which many of us use. It's not social media, but it's digital content, between their patient encounters, when they're on duty. They're not stopping and opening textbooks the way that we used to. I don't think our new works has any textbooks anymore. So they're getting really up-to-date information from podcasters or bloggers, who are combing through the medical literature as it comes out, and reporting it fairly real-time rather than textbooks, which are outdated the day they come to print.

And it's a challenge as an educator. This rapid knowledge translation keeps me on my toes at work. So let me give you a story. A while back, I was intubating a patient with my resident, and I asked for cricoid pressure to be applied, pressure in the anterior act to move the trachea. And his response was, "On this morning's episode of the EMCrit podcast, they reviewed a paper that says you don't have to do cricoid pressure anymore."

Ruth Adewuya, MD (host):

Oh gosh.

Michael Gisondi, MD (guest speaker):

Yeah. So I'm standing there with a blade in my hand. I did it anyway, obviously. I wasn't changing my practice based on the intern's interpretation of a podcast. But I also listened to that podcast on my way home, and I pulled that paper that they discussed later, because you have to stay on your toes with learners that are learning in an environment that's just quicker and faster. All right, so that's my answer to question number one.

Question number two was, have we adjusted our curriculum enough? And that's a really good question. There are many academic medical school faculty members out there who are creating really valuable rich content for these sites all of the time. And that content is being formally introduced to trainees sometimes, not all the time.

But a lot of trainees are finding these sites on their own, and they're judging the reliability of these sites on their own, perhaps without skills to be discerning. And this is something my colleagues and I on the

same paper that I referenced, called, "Waiting Curation." So with the kind of trial and error engagement with different learning resources, particularly digital learning resources, until you find one you like and, most importantly, trust, and the trustworthiness is really interesting, how long it takes for a listener or a user of one of these sites to decide they're trustworthy.

But there are some cool examples of curriculum design that formally include social media, and it doesn't overlook it because of some purist or historical or stuffy textbook-only instructional approach, but it's embracing new learning resources in media. So in emergency medicine for instance, we provide a weekly reading curriculum for our residents, and it lists relevant textbook chapters, great extra lists, comparable podcast episodes, and blog posts that we vetted, so the residents can choose their preferred learning resources, so the two are fairly equal in quality.

Before Stanford, I was at Northwestern, and while I was there, we changed our journal club to include one article and then one relevant podcast paired together. And when we would teach residents how to critically analyze the medical literature, which is the point of journal club, we would also teach them how to critically analyze a medical podcast, which is a new skill, and a skill that you have to be able to make this decision of trustworthiness.

So I think we have to equip learners with those skills and not relegate them to some hidden curriculum. And I'll say one last thing. When designing curricula that goes beyond podcasts and blog sites, and uses larger social media platforms, I think you need to understand which platforms appeal to which generations of learners.

Your audience of learners can be very broad across many generations, but you have to target them. You can't expect today's trainees to engage in a Facebook community that's medically oriented to some part of your curriculum, because they don't use Facebook. They hardly use Twitter, even though it's presumably the preferred platform by medical school faculty.

And if you're going to teach college students, they're on Instagram and TikTok. You think of Instagram as just the site you put your vacation photos. There are a number of educators and particularly physician influencers that are using Instagram for educational purposes, and certainly TikTok we've seen with physician influencers and educators as well. These tools could be leveraged to teach, if you're a creative educator.

Ruth Adewuya, MD (host):

Let's talk about your followers. You have almost 5,000 followers on Twitter. You're on LinkedIn. Could you elaborate on your presence on social media, and how have you used it as a platform, and why did you decide to be on these platforms?

Michael Gisondi, MD (guest speaker):

Okay, so I have a cute story. I got started in social media in 2014. I know the year, because I had absolutely no social media account of any kind, no interaction with it at all, until I attended this Medical Professional Society meeting in 2014 and the lecture was called, "From Twitter to Tenure," and I thought, I want tenure. So I joined Twitter. That's literally how it went down.

It was a panel of educators, one of which was a Stanford School of Medicine grad, Dr. Michelle Lynn, class of '98, she's at UCSF now, and she's the editor-in-chief of the Academic Life and Emergency Medicine blog site, which is very, very successful. She described dissemination of content, that she could write a blog post about some topic, and instantly there were readers all over the world looking at that content. And if she wrote the same information in a journal article in some obscure journal, there would never be that degree of knowledge translation. There would never be that degree of dissemination.

And as an educator, I think that's really powerful. I ran a podcast of my own for about eight years. I just turned it over to someone new. And in our first several episodes, we were looking at our distribution of our audience. It was on every continent minus Antarctica. And within seven days, our statistics were showing that it was getting really broad audience attention.

So I find it very powerful, and I really attribute it all to going to that "From Twitter to Tenure" panel. I'll say in terms of my followers, right? So I have a modest amount of followers, so I have 5,000 followers, and that's after eight years of accumulating them. I'll say a lot of them are probably listeners to my old podcast, so that's probably how they got there.

But there's many of our colleagues who are physician influencers and physician activists out there with tens of thousands, if not 100,000 followers, and they may be the exception, but I do think there's commonality between how we approach these platforms, and we use them in very purposeful ways.

I use Twitter for professional purposes. I think the majority of physician users of social media tend to be on Facebook or Twitter. And I'll share, despite all of my interests in social media and I teach a class on it in the university, I've never had a Facebook account.

Twitter is where my audience of users really are. I'm an educator and I'm a researcher and I'm putting out content that I want other physicians and academics and trainees to see, and they tend to be on Twitter.

If we're going to continue with the generational thing, your 30-ish year old to 60-ish year old academic physician is going to probably be on Twitter for content. To that audience, I tend to post almost exclusively about three things. I post about emergency medicine, or medicine in general. I post about medical education, medical education researcher, and I post about Stanford sports because I love the Tree.

Sticking to a couple topics is best for professional branding, and I do break my own branding rules every now and again. I might tweet about something in pop culture or whatever, that I think still personalizes a physician in some ways. It doesn't always have to be professional and stuff.

During 2020, I certainly broke my branding rules. I was rage tweeting with all the misinformation related to both the COVID and the election. So I definitely left my space a little bit there, but I felt like I should have a position. I have a social platform, I had a bunch of followers and I felt like misinformation in particular needed to get called up at that time.

But all that said, I spent very little total time on Twitter. I want everyone to know that I'm not on it for hours a day, and a novice should not be intimidated or concerned that they're going to waste hours and hours on the site.

So I get on there, I post something, I maybe scroll through other posts for like a minute, very briefly, I'll retweet posts that I do think should be amplified, generally of my colleagues, and then I'm done. So 10 minutes a day, depending upon how complicated the post I'm writing is. I'm known to do it in the line at the grocery store. By the time I've paid for my groceries, I'm off Twitter again.

Ruth Adewuya, MD (host):

What are some ways for physicians to utilize social media to both share their work and learn from those also online?

Michael Gisondi, MD (guest speaker):

To get started, I recommend that physician users curate medical or scientific content and post that. So what do I mean by that? If you're online and you're reading a journal article, and I would say whether

we're talking about our more senior physician faculty who are on social media, they are certainly reading journals online. So you're reading a journal article online, and you think it's interesting, and you want to share it with people, click on the "share article" button, or there's an equivalent that is on almost every journal site. And then it'll give you a number of icons, click on the Twitter icon, assuming you have an account, and then it's automatically going to make a post for you, a draft post that'll have the title of the article, the journal name, and a link to the article at minimum. So that's curation. You could go beyond that when you're curating content and add context.

And this is what creates your professional brand. So at the top of the post, just put a single sentence reason why you posted it, why did you find it interesting? So, "I found this article interesting because," or, "I learned X from this article," and describe what it is, single sentence, and then tweet it out.

And you can do the same thing with your research findings as well, though be careful not to use specialty-specific jargon.

Do use numbers. Numbers, get people's attention. So, "We found that this drug lowered serum X levels by Z percent." Those are ways to curate content for your colleagues. There's this physician down at USC, Dr. Jeff Riddell, he's a medical education researcher, and I followed him online, and Jeff and I are good friends. And whatever Jeff posts online, whenever he posts a journal article, I always stop and read that article, and every time I'm like, "That's a really great article."

Every time I see something he posts, I think it's really interesting. Again, there's something there, and I think you're feeding an audience who wants to learn in medicine, but you just have to package it.

I think another way that you can get your research papers out there more broadly than to just tweet about them, is to blog about them. I think you should write a blog for every research paper you publish, and write it like a newspaper article, the opposite of a journal article.

A journal article is all about the windup: intro and the methods. And then we get to the discussion, we get to the storyline, where in a blog post, it's written like a newspaper article. So you lead with the story upfront, your major finding upfront, perhaps some background information or some data.

Think about when you read a blog post, like you're at the grocery store in line again, you're on your cell phone, and you read the first couple of paragraphs, you scroll a little bit and you stop. So make sure you put that stuff up front.

So then you tweet the blog post out, or you post the blog post to LinkedIn and these will do a couple of things. It'll drive traffic to your article, and it will improve the article-level metrics and author-level metrics, if the link from your blog post or from your tweet or LinkedIn post goes directly to the journal itself, not to PubMed but to the journal, it'll drive your own metrics.

Ruth Adewuya, MD (host):

Do healthcare organizations or systems guide clinicians on their use of social media networks professionally?

Michael Gisondi, MD (guest speaker):

Yeah, absolutely. And it's interesting how that devolved, right? 10 years ago, medical schools and hospitals and things were very concerned that their employees or trainees were going to write crazy posts, and there's some of that out there, but they had to create pretty strict social media guidelines. And I think those days are behind us.

I think healthcare organizations figured out how to use social media, in very practical and useful ways. They guide physicians in the use of social media in two main ways. Everybody has these social media

guidelines, and you should be aware of them and follow them. So Stanford University has guidelines. My department has our own social media guidelines. So they're there, but they're not as draconian as you might suspect, and they offer a lot of latitude to express yourself in your opinions.

I think the less common way that an organization can guide a physician is through formal social media training programs. And I think these are highly valuable if you can find them, they're uncommon, but if you have access to them, they can teach you the functionality of a platform, how to strategically engage on it, how to professionally use it.

Ruth Adewuya, MD (host):

What are your thoughts on using social media for direct patient care?

Michael Gisondi, MD (guest speaker):

For direct patient care, I would advocate against that strongly. Personally, I don't use any social media platform to engage in direct patient care. None of them are HIPAA-compliant, to begin with.

I do think, though, you can do great public health messaging and health education for platform users in general. So not really direct patient care, but health education. And you can do it on all sorts of issues that are controversial. But again, you can use your societal platform as a physician to comment on these things. Vaccine use, gun safety, suicide prevention, COVID in general, drug use. None of those things are direct patient care, but you're educating your potential patients, the users that are out there.

I'm pretty conservative about how I use social media with any patient information. I tend not to post really anything. There are colleagues that, though, will post interesting ECGs, or interesting imaging studies, and what they learned from them, or they're trying to disseminate. Things like the COVID pneumonia chest x-rays, for instance.

I tend not to do that. And I would argue that if you're going to do that, you have to do a really rigorous de-identification process. So if you can switch the patient's sex assigned at birth, if it makes sense with the case and imaging, change the age by a couple decades, do whatever it takes to make the patient identity non-discoverable, that's very, very important for the protection of our patients. Again, I'm pretty conservative about how I use patient artifacts.

Ruth Adewuya, MD (host):

You alluded to the concept of misinformation earlier in our conversation. So what are some things physicians can do to combat misinformation, and how should physicians navigate these conversations?

Michael Gisondi, MD (guest speaker):

This is a really important topic, and I'm grateful that you brought it up in our discussion. So I'm going to tell one other quick story, and I alluded to it already.

In 2020, I really was rage tweeting, to go back to my Twitter thread. I was just so enraged by falsehoods that were posted online about COVID, and some of them fell across political lines and things.

And I teach this undergrad class that I've talked about, and a bunch of my undergrads were like, "You're using social media differently than you taught us in class," which I thought was funny. And one of them ended up writing a grant with me, from the Stanford Ethics, Society and Technology Hub offered an internal seed grant, and we got money to put on a conference about social media and COVID misinformation called Infodactus in August 2021, and before I wrote the grant, I didn't actually know the word "misinformation," so I got interested in this topic, I started this conference, wrote a grant. We've

written several papers on this topic, giving grand rounds on this topic. Now it's really become something that I'm very passionate about.

So I think that all physicians should address health misinformation when they encounter it online, like directly, immediately do it. And I recognize, though, that there's this phenomenon called "healthcare provider social media hesitancy," that refers to the reluctance of a health professional to use social media for professional purposes in general. But a lot of that hesitancy is specifically related to engaging with users about misinformation.

And I get those concerns, but I would counter that it's our responsibility as stewards of public health information, to use our societal platforms and to give accurate health information in the face of just an overwhelming amount of misinformation online.

There is a study that showed that about 50% of COVID misinformation originates on social media sites. 20% of health misinformation is spread by celebrities, sports celebrities, TV, politicians, something called pop-down misinformation. So it's out there and it's rampant, and Vivek Murthy, our surgeon general, published a document about this July 2021, where he was quoted as saying, "Combating health misinformation is a whole-of-society effort." So he's implying that there's this ethical or even moral stake in the game, that physicians or healthcare providers in general.

Ruth Adewuya, MD (host):

We know that there are so many sources of information on social media and thousands of self-proclaimed expert as you mentioned. How can physicians establish and verify their expertise, as they aim to relay factual information online?

Michael Gisondi, MD (guest speaker):

Yeah, I think that's a very important question of credibility. How are you going to effectively debunk health misinformation online, with users who don't know who you are?

So some of that credibility comes from being a physician. We have a societal platform, right? Doctors and nurses are still considered the most trusted sources of health information, including COVID information, despite some backlash against us in the last year.

That credibility, though, is stronger with a patient who came to seek our care, who's sitting in front of us, than the general public who's online, who are strangers to us. So that's why I think offering scientific references with your posts is really important. It adds some credibility. So if you're going to post something, link an article or a quote from the CDC. And then your institutional affiliation cares a lot of weight as well, so we can't forget the impact of our words that are coming on behalf of our institution. You should leverage that credibility.

I do think social media and misinformation training that's offered by institutions will make physicians much more comfortable with this process and engage with online misinformation, just because they're better prepared to do it, and they'll perceive that that training is a signal of support by their institution. They're not going to be as worried about what they say.

And I think institutions should follow the direction, honestly, of the Surgeon General and not abdicate their role in public health online. They worry, I think, sometimes about brand image or media coverage, and their posts tend to be very promotional in nature, and I think we could do a lot more health education with social media sites and institutions.

Ruth Adewuya, MD (host):

I want to go back to what you were talking about, the research that you've done around misinformation and immersing yourself in that. What is your process, and how would you recommend that clinicians debunk misinformation online?

Michael Gisondi, MD (guest speaker):

It's not my protocol for my research, but one that I teach. There's five steps that you can use.

First, when you see a post that has misinformation, step one is to just respond immediately. Don't let it linger online unchallenged, because just more people are going to read it, and it's going to misinform more users. So just stop what you're doing and respond.

Step two is to start your post with correct health information. So say the right thing first. Say the accurate information first.

Then step three is to refute the misinformation, which you're only going to state once.

Then step four is to put your reference.

And then step five is to repeat the correct health information a second time, so they hear the accurate information twice.

This is very similar to what you should do with patients in your clinic if you encounter misinformation, right? It's acknowledging the misinformation, following it with a fact and then saying why the misinformation was once thought to be true, but now we know that the accurate information is in fact true, and this is why. And then you end with repeating the correct factual information again.

They're very similar online, and I'll offer a fun example. So Tito's Vodka responded to health misinformation in March 2020, the beginning of COVID, when some on social media started posting that you could kill COVID by washing your hands with vodka.

And Tito's took this very seriously, and their tweet in response is fantastic. Their post followed exactly the five steps. They said, "Hand sanitizer needs 60% alcohol." There's the fact, but their vodka only has 40% alcohol. "So see this reference from the CDC." They linked a reference at the CDC, and then they said, "In summary, our vodka does not meet CDC recommendation." So they repeated the facts. So fact debunk, reference, fact repeated. Just brilliant tweet.

Ruth Adewuya, MD (host):

Apart from misinformation, what are some other dangers of social media that clinicians should be aware of?

Michael Gisondi, MD (guest speaker):

This is really important. Entering the social media space is certainly not without risk. There are studies documenting the harassment and bullying of physicians who engage in public health or political advocacy, particularly around socially-charged topics, abortion rights or gun safety. And I'll call your readers' attention to a research letter that was written by Pendergast and Aurora. It was in JAMA Internal Medicine in January 2021, and it received a lot of press. They found that a quarter of physicians online have been harassed in some manner, and one in six women physicians have been sexually harassed, leading to many women disengaging with social media altogether. So that's really dramatic.

I would say in my anecdotal experience, that number is much, much less if you're talking about topics that are politically or religiously controversial.

You're tweeting about my medical education research study that was just published. I think the risks of harassment dropped significantly, though you are a public figure, and any public figure such as a physician can get harassed anyway, and I certainly, when I was breaking my social media rules during my rage tweeting, I got a lot of responses.

I think the other perceived danger, and I'm going to say it's perceived, is that your employer is going to discipline or terminate you if they disagree with your tweet, and unless your tweet is egregious, I think that's a somewhat silly concern. I think any reasonable physician who doesn't post about patients, and remains a steward of accurate health information, would be well within their institution's social media guidelines to offer opinions. I think it's highly unlikely that Stanford would react to a professional reasoned post about gun safety, or a COVID vaccine, or some similar top societal issue if the content itself is accurate, and the post is well intentioned.

Ruth Adewuya, MD (host):

Throughout your conversation, some of the learnings that I've heard is one, ask clinicians. We're all stewards of making sure that our community is safe by disseminating accurate evidence-based education.

The other thing that I heard is not only putting it out there, but debunking misinformation, and thank you for that stepwise process of what the fact is, debunking it, putting a reference, repeat the fact. But also, I want to circle back to where we started in the beginning around medical education as we wrap up our conversation. What's your advice for clinicians who are considering utilizing social media platforms for professional reasons, or even as medical education researchers?

Michael Gisondi, MD (guest speaker):

My last piece of advice would just be not to fear the technology. It can be clunky at first. There's a great blog post called, "Mom, This is How Twitter Works," in momthisishowtwitterworks.com. You could go and learn how the platform works, so you really don't be overwhelmed by the tech. There's a technique to all of these posts. It comes really quickly.

Ruth Adewuya, MD (host):

Thank you so much for sharing your insight on this topic with us.

Michael Gisondi, MD (guest speaker):

I'm so honored to have been on the podcast, and to talk about this topic. Thank you so much for the invitation.

Ruth Adewuya, MD (host):

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