



American Society of
Anesthesiologists™

Central Line
Episode Number: 58
Episode Title: Enhancing Patient Communications
Recorded: January 2022

(SOUNDBITE OF MUSIC)

VOICE OVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome to Central Line. I'm Dr. Adam Striker, editor and host, and today's show is all about patient communications. To help us explore this important topic, I welcome my colleague and friend, Dr. Kraig de Lanzac. In addition to serving as Assistant Professor of Anesthesiology at Tulane and Clinical Director at Lakeside Hospital, Dr. de Lanzac is the ASA's Assistant Secretary and the former Chair of the Committee on Communications, a position I'm now honored to hold. Kraig, it's great to have you back on the show.

DR. KRAIG DE LANZAC:

Adam, it's great to be back and you've been doing some fantastic work with the Central Line, so I hope your listeners are enjoying it.

DR. STRIKER:

Thanks. Appreciate it. Well, I'm glad you're back because this is an important topic that we're going to talk about, which is a patient communications. And I know we both, we both know it as many of our listeners do that good communication practices are key for physicians. So let's kick this conversation off, reminding our listeners why good patient communications is so important.

DR. DE LANZAC:

In general, communication, just members of the population, humanity, it's important for us to communicate with each other. And as physicians it's important, and particularly for physician anesthesiologists. We have such a small window for those of us who work in

the O.R. Slightly different in the ICU and certainly different the pain management clinics. But we have such a small sliver of time to gain the patient's trust, to have them trust us, to understand their needs and for having them understand what it is that we're going to do for them on that day. So we we have to be master communicators at the bedside.

DR. STRIKER:

Yeah. I'm glad you brought that up about the short interval because it it makes the this whole program especially relevant for anesthesiologists, rather than perhaps some of the general communication guides that we might often see around our organizations. So as we talked about before, I'm now the Chair of Communications Committee, which I inherited from you. And like you, I obviously share a passion for communication. So this topic is certainly near and dear to my heart. And one thing that the committee grapples with, and I know it has for a while, when you were in charge as well, is that six out of 10 Americans do not know that an anesthesiologist is a physician, and many don't remember meeting their anesthesiologists when they've had surgery. Can you talk about why the lack of public awareness of our specialty is a problem?

DR. DE LANZAC:

Absolutely. And you are correct. We we've grappled with that for years. And that's been the impetus for our When Seconds Count program and now for our Made For This Moment program, trying to improve our public relations of what an anesthesiologist, a physician, anesthesiologist is. And we always looked at our large, overarching campaigns. But one of the things that I kept going back to is looking at that only six out of 10 realize that anesthesia for physicians and having that experience that I know both you and I have often in social circles telling someone that you're an anesthesiologist and they go, "Oh, you know, you didn't want to go to medical school and become a doctor?" And having to correct that. So I started to think a lot about that, and we as a committee thought a lot about how can we improve it? And it led me to realize and I'll do the numbers. Many of the listeners may have heard me go through this before. But we have thirty thousand active ASA members. We have fifty-four thousand total members of ASA, but thirty thousand active practicing. And I tell folks, if we gave two thirds of us the day off, everybody take the day off well and go to work with ten thousand anesthesiologists. And if we had a light load and only saw five patients in a day, each of those patients only having one family member, that's one hundred thousand interactions in a day.

That's 10 interactions per each of us at a minimum hundred thousand interactions in a day. In a week, that's a half million patient and family member interactions. And a month, you're talking two million. So two million opportunities, not all unique, but two

million opportunities for each one of us to inform the public, inform our patients what physician anesthesiologists are, what we do, who do we work with. What is anesthesia? Is one of the questions that comes up. And if we build on each other's communications, it gets even better. So that to me was where can we really drill this down and work at it? So it's so important for us.

I tell people I'd love to have name brand anesthesia. I don't want to be called anesthesia. I don't want to be referred to. None of us like being called anesthesia. But I would love if someone came away, and they may not remember Dr. Striker, but they may remember Dr. Adam or Adam or something with an S, but something you never remember. Dr. Striker took some time. He spent time with me. He told me what to expect. He told me how things went afterwards. He told me what to do for next time. And he might have even given me some advice about some medical conditions that I could have tuned up.

DR. STRIKER:

I think this is the key to this idea that you had and now the program that we have implemented from the ASA, which it's the Enhancing Patient Communications Program, officially. The two key pieces, number one to proactively do a better job as anesthesiologists conveying to patients and thereby the public what it is we do and who we are. But secondly, which I know that a lot of our specialty has clamored for, is the ability to further enhance the job we do with communications so that that may not even be necessary so that patients do remember who we are. We do such a good job as a specialty taking care of patients, but I think we also do a good job of trying to do it under the radar and behind the scenes. And we're so good at it that the public does not perceive us as the physician specialists and experts that we truly are. And I think we really need to be our own advocates in that regard. And so this program helps us to take advantage of the short time that we have with our patients. We don't have the advantage of meeting them in clinic, most of the time. We have a short time to get to know them, to develop a rapport. We have to take advantage of that time to make sure that we convey the job we are going to be doing for them the whole entire time that they are asleep, that they're under our care, but also to make sure that we give them the opportunity to remember who we are when they leave our care.

DR. DE LANZAC:

I agree. I think I think you hit on several good points there because, first of all, we've gotten very good at what we do. We can make things look so easy, so safe. I always tell residents or trainees I work with, with just an epidural, thinking about what a labor epidural does. It's kind of magical to stop and think about. We're going to play some

medicine with a needle into a place we can't necessarily see, even with ultrasound. We could see a little better but can't see. And it's going to keep you numb for hours and hours. And we do that effortlessly, and we do that quickly and very efficiently. And patients don't realize it becomes a technique as opposed to going in and explaining to patients a little bit about: We're going to do this. Here's how we do it. Here's how it works. We're going to get you through comfortably, and I'm going to be here to make sure that it stays that way. We're humble, folks. I think as anesthesiologists, we're very humble. We don't always pat ourselves on the back. Rarely do we come out and tell them in the waiting room, Boy, it's a good thing I was there or else, you know, your grandma may have had a much tougher time. We don't do that, but maybe we should do a little better job of sort of fluffing ourselves up to to our audience, which is our patients.

They're audience, they're our patients, they're our wards. They're people we have to take care of. And in doing so, communicating with them, I believe, helps them. And we've certainly seen evidence where it helps us. You know, I love talking to patients. I know you do as well, and I think there are some of us that it is very natural. Some of us said, it's not. For me, I was a shy kid. So you shy kid, go to medical school. You had better learn how to talk to patients and come out of that. So it became for me a lot about keeping the situation light, explaining with the serious nature how we're going to do things, but letting the patients know what to expect, when to expect it, what I'm going to do, and what the dangers are and how I as their anesthesiologist is going to help them through.

So, you know, putting together this project and coming up with these ideas and and the group has been fantastic, included yourself at Matt Hatch and Victor Davila and Asha Padmanabhan and Brooke Trainor. But what you all did was a great job of pulling together research, information that if someone wants to get better at it, they can refer to this enhancing patient communications and look at some tips.

Maybe it's about active listening tips, you know, maybe I haven't practiced those techniques in a while and take it with me. It's not preaching at me. Here's what you should do, but it's sort of steps for me to get better. It's like, how do I get better doing ultrasound? How do I get better at my regional techniques? Same type of skill: communications. And like you said, our goal, my goal ultimately is patient, feels good about the communication. They trust me. They're satisfied. We have a good bonding period of time there. But also, I want the patient to go out and say I had a really good experience at XYZ Hospital and it was with Dr. de Lanzac, and I was thrilled he's there. You should ask for X, Y and Z, that person, that technique. And get the patients to ask to meet their physician and ask about the anesthesia delivery. And that's what I think ultimately is our goal. And then patients are helping us as well. They come in

knowledgeable when someone has a policy that they want to change legislatively about removing physician led anesthesia. Our patients become our best advocate because they know what we're doing.

DR. STRIKER:

Absolutely. You know, you brought up how you feel better yourself as a practitioner when you have what you perceive as great communications interaction with your patients. And I would also add to that, we know that burnout is helped by good communications. I know my days even when there are rough days, when I have that preoperative interaction and post-operative interaction and have talked to the family and they're they're grateful, they're satisfied, they feel like everything went well. I can't tell you how much that just mitigates the stress and the angst from a from a rough day. And so I think that's that's another intangible benefit of engaging in optimal communications and trying to improve your own communications.

DR. DE LANZAC:

Absolutely. Adam, you mentioned something about post-operative. You know, a lot of what we talk about frequently is how to talk to a patient ahead of time, how to get information. You know, we teach residents we're gaining medical information, but we don't always teach residents about how to talk to patients, how to talk and address family. But the second part of it is the post-operative. Closing that loop afterward is one of my favorite things to do. And it could be in the form of the formal post-operative visit. That's one thing. But gosh, walking down the hallway as you're going to catch a cup of coffee or after the day is over and you happen to bump into one of the family members and just having that second interaction, boy, you know "your husband John did great today. I was really impressed." Having that second chance at talking to the patient or the family is so rewarding, especially when you get to the private area, to the patient's room, and you can say you "remember that we were worried about how nauseated you were last time. This time we did a couple of different things. And how did you feel? You felt good. Oh, great. Perfect. Here's what we did. Here's why we did it." And that is extremely rewarding. It also informs the patient.

And what if it didn't go well, you know, we always have cases, Adam, where maybe it could have gone a little better. Patient did have some bumps in the road. They're now concerned about their anesthesia effects for the next time. Does it make a patient, not have surgery when they need surgery? I always worry about that. So I like to tell them, you know, we had a rough time. We may, we had some difficulty. Your nerve block didn't work as well. We've replaced it. It's better now. But please don't think that's going to be the problem next time. Ask some questions. Happens with labor epidurals. You'll

hear a mom say “I just wasn't as comfortable at the end. I don't think I do an epidural next time.” And just being able to take those couple of moments to say, “Well, here's what happened. And here's how you were in a very difficult, prolonged laboring. Please go ahead and talk to the anesthesiologist when it comes to that time.” I think that's so valuable it helps the patient, and that post-op visit is also where we can tie back into the medical care of the patient. You know, you've had a patient raise ... their blood sugars weren't running well, they thought they were controlled. We've now seen a full day in a stressful situation, their blood sugars. We could tell them, I think you ought to go home, take a log, get back with your primary care. And if you want, I can call your primary care doctor for you. That really puts a cap on the patient care experience for me.

DR. STRIKER:

There's so much opportunity for us to do a better job of promoting our specialty simply by being there for the patients more than we might even think we are. I wanted to get your take on the idea that communications, in fact, this has been studied, that patients prefer, more than good outcomes, they actually prefer a seamless process where they actually understand and have better interactions with their physicians. And likewise, physicians vastly overrate their own ability to communicate effectively. What is your take on how that plays currently?

DR. DE LANZAC:

So, you know, you hit on, as I view, sort of a systems thing. Even when you go to a restaurant or store and you watch an efficient process, you feel reassured. Wow those people are experts, they they know what they're doing. And no more is, nowhere is it more important, I should say, than in a hospital and procedures, in a surgery center, in an obstetric area, in the ICU, for people to see a seamless process where there's a, there's someone in charge, there seems to be things in a flow. They don't want to hear about. Oh, shucks labs late today, and gosh, I wish so-and-so would have shown up. So it's also controlling the communications to keep the negative out, but demonstrating that flow. And I think it gives us a great opportunity to say, “I'm Dr. de Lanzac, I'm your anesthesiologist, I'm a physician that's in charge of everything from when you start today to when you go home. And I'll even call you the next day.” And I'll give patients an idea of what I'm going to do, but I'll lay out sort of the script for the day. So the what to expect before they even know it. They've heard from their surgeon what's going to happen? But we probably give a more grittier version. You know, we're all going to get you on to another bed. It's going to be a little cold. We're going to start to give you medicine three IV. You may feel some of a tingling, might even a burning sensation when it happens. You're falling off to sleep under general seizure. And explain what that wake up looks like, especially when it comes to pain. And right now, we've got a lot of

folks that, even with our nerve blocks and all the techniques we do, patients still have post-operative pain and they need to know that you may wake up some discomfort. You may wake up with some some irritation or you may feel like you're sore. Present that so they know what that routine is and then you process look smooth.

I think, when we talked about this project, all of us in the Committee on Communication, probably felt like others had listened to our poor communications at patient's bedside. But all of us have heard a colleague, surgical colleague, fellow physician anesthesiologist on the other side of the drapes and going through a checklist. Any heart problems, any lung problems, any ... ? And sometimes we have to do that. We have to do that quickly. But there's ways to make that conversational, and we've kind of cringed and said, "Gosh, I hope I don't sound like that." So I always tell people, Go to that patient, you may be rushing--we're all rushing around--have some knowledge of what's going on with type procedure they're having done, some information of the history. Hopefully you've got a chart. Stop outside the door and just take a deep breath, collect yourself, walk in, smile on your face even though it's hard to see with masks these days, you can still see the eyes, and greet everyone in a room and say, "Hey, I'm Dr. de Lanzac. I'm your physician anesthesiologist. We're glad you're here. How are you feeling today? Before we even dive into something, how are you doing today? How are you feeling? You know, how's your experience been?" Patients love that, and they open up and you might get a little more conversation than you want. But that's where you learn how to negotiate through that conversation to get the medical information you need.

Just tying into the family members is tremendous and something I missed when when we've gone through all the COVID precautions, when we may only have one family member at this time, we may have had two in the past. That was a dramatic change in how we communicated with the patients. You know, having to get the family members sitting in a car outside is quite a challenge. But it's made me and physician anesthesiologists better as communicators because we've had to learn to do some things quite different, and not seeing someone else's face and just the way they move their mouth is different for all of us now. So I think we've done quite well, and I think the information in this enhancing patient communications kit is going to help a lot of people. And by helping us, it helps our patients. You know, anything we do to refine ourselves really helps patient care in the long run.

DR. STRIKER:

Absolutely. There's there's a lot of great suggestions in this program. A lot of the specifics we've already talked about and we're going to continue talking about are in there. But the idea behind the program is not to be a prescription for exactly how to do

things. It's to really help every individual anesthesiologist improve their own communications. They can tailor their own, pick and choose what they think would improve, get some ideas, kind of reevaluate what they do, but I hope that point gets across that this is not to prescribe how you communicate with the patient, but just offer a lot of avenues to everyone to improve their own.

DR. DE LANZAC:

Absolutely. And I think one of the things we could dramatically do better is sort of the frequently asked questions. You know, we get some questions asked all the time. And I've always practiced in the anesthesia care team with residents or nurse anesthetists, or delivered my own cases, my own care, one on one with patients. So a lot of times you'll get a question, for example, are you going to be with me the entire time? And I've heard some colleagues fumble with that question. I've probably fumbled with it, but there's probably some really good ways to answer that question. It's covered in this toolkit, but I let people know when they ask that question. If I already have presented it, I sort of let them know who the cast of characters, to use the term, is going to be for the day. You know, I'm your anesthesiologist. I'm actually in charge of all of your care today, and I'm going to be working with a nurse anesthetist, and I may say a little bit about what the nurse anesthetist is, or maybe personally, you're going to meet Jeremy.

He's very good. He's going to come in. He's very thorough. He and I will be working throughout the day, or I'll let them know. The resident is Dr. Johnson. He's coming in with us and let me explain. And it allows the patient to see all the the players and what the roles may be. And that often prompts some questions that can be very confusing because for many patients, it's the first time they even realize, wait, there's two or three people that might be caring for that same aspect, and I let them know, just as the surgery team has multiple players, the anesthesiology team does as well and what the roles will be. And I find that to be a question many, many of us get very often. And there are some easy answers to it, probably better than mine, but there are some easy ways to explain exactly. What is really nice to do that first, because if others answer that question, they may have a slightly different answer for what it is that we, as the anesthesiologist, do in the care team in particular.

DR. STRIKER:

Absolutely, and those of us that practice and the team model who embrace it and find it valuable should not be afraid to specifically articulate what our role is in that leader of that care team. You're in charge of the anesthetic care. Here's why I'm working with. I, I think that I think we should be upfront with patients and certainly embrace the idea that

we have a team of individuals that are that are all very good that are going to help take care of just the anesthetic portion.

DR. DE LANZAC:

Yeah. To that, I even bring in my other colleagues if for some reason it looks like it's a case that I may, at the end of the day or at the start of a morning of an overnight case, may have to have a colleague take over, very often I'll ask my colleague and we'll go out and talk to the family if they're in a waiting room and I'll introduce "this is Dr. Jones, and he's actually going to be taking over from me." And I feel it's so important to make sure they just don't want to see another person suddenly pop up. So having some of those links is that connection and trust that we have with the patients through good communication.

DR. STRIKER:

Now that's a great point. It's a great thing to do, but it's it just gets to the basic principle of letting the patients and the families know that you care, that you're attentive to, you know that you're not forgetting about them, they're not just a cog in the wheel. Another great tip.

DR. DE LANZAC:

Yeah. We're so busy, Adam, that, you know, we're all, especially now, we're all running around and we're not going to have the best communication. If we sat down, recorded every communication we have with patients and reviewed it, they wouldn't be the best. But looking at this and stopping for a moment and having this conversation we're having today, but looking at how can we improve our bedside communication as an anesthesiologist? And we didn't talk about it, but there's a fair amount of literature out there about a clinical practice, an internal medicine physician who can sit and have some time, but there's not a tremendous amount of research out there about how does an anesthesiologist, a physician anesthesiologist, improve their communications. And that's another thing that is open for us is, this type of toolkit is certainly open to be refined and to be looked at. How did this improve patient satisfaction? How do you improve physician satisfaction on our side? And I think that avenue is out there. So as we go forward with this project, and just talking about bedside communications, is going to help that, it's going to help it for our residents as well.

DR. STRIKER:

Yeah, certainly. And let's not forget that each patient is different. And so what's going to work for one patient is not going to work for another.

DR. DE LANZAC:

Yeah, that's a great point. So very commonly, especially with our sports medicine program, we have some young athletes that come through, and of course, the question always comes to "what high school did you go to?" Once you got that, what high school, regardless of the answer, the competitive schools, my school, et cetera, it always at least gives us another avenue to discuss something different with the patient. And it just lightens the mood, especially in that age group. You know you're talking adolescent and young adult age group. When you already engaged in the patient, you know it's we're not ignoring them as we do with some of your your patients might be neonates, Adam, but we're bringing them into the conversation and younger kids gets to be a challenge. You're an expert at that, I'm certain. But I always enjoyed trying to interact with them to see what level they want to interact with me and bringing them in the conversation. And same thing happens with the older patients when you have to do it. And I think there's where levity can play a part to keeping things light in the room, keeping things at a level that patients start to realize, OK, I'm comfortable because my physician anesthesiologist looks comfortable. Not joking, not you're not coming into a dark situation--patients had some significant problems in making jokes--but at least not being so serious and rote and scripted, that you can have an interaction with patients. Just conversational language always helps. And then you get into the more fine parts of medical language and fine tune. And that's a great point to bring up, too is: trying to avoid the jargon is certainly talked about in the toolkit here. We're so, so used to being able to communicate with each other, and our residents are taught to use the technical terms. But it's hard for them to think back and go to those normal terms, especially as you're talking to high school kids, regular kids, and to tracheal tubes and things like that are very confusing. So using general terms such as a tube or a breathing device. Sometimes I use the term a snorkel. You know, the kids kind of know what a snorkel is, and I tell them that tube looks like a snorkel, and it brings out a little shine in their face

DR. STRIKER:

Well, you try to feel it out with each patient and just just be a normal person like you stated. But you're right about the jargon. I think a lot of people know that, in general, but I but in practice, that's a lot more difficult.

DR. DE LANZAC:

Very much so. One of the words that is coming out about my brain was individualized. You know, you really have to individualize the communications. And when we talk about restaurant, for example, we have a conversation. If you turn to your right head a colleague to your right, you may have one conversation at a time. Your colleague to your left at that point is a different and it's the same here. It's you know, you're talking to your grandmother or are you talking to your buddy from school? And if we can individualize it, I think maybe we fall a little bit, we all do, we fall in that trap of, I'm going to go in there, I'm going to get through my script, I'm going to move on and we're going to get forward. But if we could just individualize and you know what, I believe the patient feels that individualization, they feel you connecting with them. You know, my conversations about high score. How did you hurt your leg? If it's something that I was, I was skiing and you can bond on that sort of thing, those little, little points in time that are so important for patients and they go, "Hey. He's a good guy. I like that guy. We're going to come back and we're going to make sure if we come back, we're going to see that doctor or certainly make sure we have a physician anesthesiologist." And I think it's just that easy. It's being human and it's being individualized with our care.

DR. STRIKER:

That more than anything just would go a huge way to. Help improve everyone's communication.

DR. DE LANZAC:

I agree. I mean, in talking to the nurses you work with and talking to other physicians, we individualize those conversations. Do the same thing for the patients and find out what it is they want. Or as we unfortunately, I know you and I have proceeded and also now followed the advent of electronic medical records and charts, and I work on an iPad based system that's very hard to look at the patient and enter information. It's it's not like writing where we could in the days. So I work very hard to have a conversation collect as much as I can, and I may even tell patients, let me capture some of the information here. I'm still listening, but I'm going to look down. And if we get pulled away, another thing is, practicing what happens when we're pulled away. Our beepers or our text or our alerts are going to go off in various ways. And letting patients know, "Look, I've got a run away for a second, but I'm going to come right back and we're going to definitely talk again." Not look like well wait, let's just finish this, sign the consent, and I'm going to run down the hall because I'm busy. That just doesn't play well and we we have to be better. I let the patients know, Heck, I am busy, but I want to get to the point where I can concentrate on you and your care.

DR. STRIKER:

Certainly. Well, the reason for this, this kind of a program for anesthesiologist is because we, we have most of the time such a short time with our patients. And it is a little different than being an internal medicine physician, who sits down in a clinic appointment and goes through a lot more detail. You have that limited time to make the impact. We've learned that all from our training. But having some guidelines, having some solid suggestions, having some substance to continually try to improve upon that ability to take advantage of that short interval of time to make an impact on that patient is something that I think is, is necessary and will hopefully be of value in the future for for all of us.

DR. DE LANZAC:

And I believe it is it is a skill. It may be innate for some less innate for others. But it is something that if we practice at it, we can get better and better. I'm always trying to get better with that, and that is just so important for us to do in the time we have, the best we can do. We're all going to get busy. We're all not going to have the perfect communications every time. But if we just get a little bit better each time, I think we're going to feel the benefit. We're going to see a benefit, maybe in the knowledge of patients. And I know the patient, regardless of any research, I just feel innately, I know the patient is going to benefit, the satisfaction, the trust levels and just the connection that they have. It's good things.

DR. STRIKER:

Well, well-stated. And Kraig, thanks for joining us today. I think this is such an important topic and a lot of these specifics that we have talked about today are included in this toolkit for the Enhanced Patient Communications Program. That program really is designed to accomplish several goals: enhance overall communications, ensure patient care is patient centered, increase public awareness of the specialty, make sure that the physician develops rapport with patients. Within that framework. a lot of the specifics that we've talked about are available for reference, and so I really encourage everyone to check this program out. It's online at the ASA website on the Made for This Moment campaign page. If you go to asahq.org/madeforthismoment and log in, you have access right there to this program and it has everything we've talked about in there. Not only will it help improve the perception of the specialty, not only will it help each individual, I think, in their own personal satisfaction of their job, but it's going to most importantly, help all the patients who have to undergo these procedures or undergo any care that involves an anesthesiologist and will will make them not only more comfortable, but just overall more satisfied with the care they received. And so, so thanks for for joining us to talk about this.

DR. DE LANZAC:

No, thank you. And I will say I just cannot commend the ASA Committee on Communications enough for taking the seed of an idea, and you and your work group, you as the chair, the entire Committee on Communications, for bringing this to fruition. And I think it's the kind of value that our members look for. And I think this is going to be a tool that they will appreciate was created by that group. So tremendous job and I am proud to have been even a small part of it.

DR. STRIKER:

Well, thank you for your original idea for this. And thanks for for those accolades. I'd like to reemphasize that Drs. Hatch and Davila and Padmanabhan and Trainor did just a fantastic job. They put in so much work into this and hopefully we'll get the opportunity even at the next ASA meeting to allow people to delve into it even in more depth. So thank you again.

DR. DE LANZAC:

Thank you. And you know, I will be in that audience. If I'm not on the stage, I will be in that audience.

DR. STRIKER:

Thanks everyone for joining us for this episode of Central Line. Please tune in again. Next time, take care.

VOICE OVER:

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