Central Line
Episode Number: 69
Episode Title: Aversive racism
Recorded: May 2022

(SOUNDBITE OF MUSIC)

VOICE OVER:

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

DR. ADAM STRIKER:

Welcome to Central Line. I'm Dr. Adam Striker, your editor and host. My guest today is Dr. Jennifer Lucero, associate dean of admissions for the David Geffen School of Medicine at UCLA, where she also holds the title of vice chair of Justice, Equity, Diversity, and Inclusion for the Department of Anesthesia. We're going to discuss marginalization, aversive racism, and allyship today. And Dr. Lucero is the perfect guest to help us better understand all this. Dr. Lucero, welcome to the show.

DR. JENNIFER LUCERO:

Thank you, Dr. Striker, for having me. Happy to be here.

DR. STRIKER:

First, if you don't mind, please tell our listeners a little bit about yourself. I'd like to hear a little bit about your story and learn about how your interest in topics like marginalization and aversive racism came about.

DR. LUCERO:

Yeah, sure. So I grew up in Los Angeles. My family was and still is from South Los Angeles. And that was an area that had incredible poverty and marginalization against other parts of Los Angeles. And so I am Mexican and indigenous, and I was the first generation to college. Much of my lived experience is through my experience in my identity, but also my family's experience.

And so my father, he was one of 15 kids, but 12 lived to adulthood. He was the third oldest and was quite brilliant. I always tell, for the the statisticians in the audience, I

always tell everyone I'm the regression to the mean because he was just so brilliant. But in order to support his family, he had to quit in ninth grade to to go work. And so never had a chance to [go finish high school and go to college. And so education to him was incredibly important. And he always encouraged me, you know, it's the great equalizer, but that was something that was very distant for us. And my singular goal was to go to college. But there were a lot of roadblocks and I very much early on wanted to go into medicine. I think I declared to him when I was around six or seven that I was going to go to medical school. And then at ninth grade, at the time that where my father had to quit high school, I was struggling with algebra and I was basically told that I wasn't good at math and so I wasn't going to be able to go to medical school. And so through that, I started to think about how I was going to do what I wanted to do, work with my community, help my community. And I thought about psychology because it seemed that that would be a way that I could see my community do clinical psychology.

And so when I went to undergrad, I went locally to Cal State University, Northridge, and was a psychology major and did well and ended up going to graduate school there also to get my master's with the ultimate plan to do a PhD. But I fell in love with social psychology, which is where all of these ideas and concepts and terms that we have learned about within diversity in health care have come from. And so through that experience, I learned about social dominance theory, implicit bias, the in-group favoritism, etc. and it was through that that I started to really thrive in that environment and ended up taking a step back when I got into graduate school, into the PhD program and thought about medicine again because I thought, this is something that I've always wanted to do. And I was encouraged by the professors and actually appear that said, you know, you can't be that bad at math if you've done so well in all these statistics courses.

And so I started my journey of doing my pre medical curriculum and then applied all over the country, worried that I wasn't going to get into medical school because there wasn't a whole lot of people that looked like me and that could advise me on what were the things that I needed to do. Medical school seemed so far-fetched for me to be able to do something like that.

And simultaneously I was taking care of my father from the time I was a sophomore because he ended up developing a brain tumor and had to have multiple surgeries. And so through this journey for undergrad and grad school, I was caring for him and had that perspective of being the patient's family member and coming from a marginalized community and not seeing anybody that looked like us. And having these conversations like end-of-life conversations and having discussions about making decisions and and not having the individual that was speaking to my father understand culturally what that meant and understanding his place and what dying meant to him. And so I think that

was really challenging. And so it informed a lot of how I then when I went to medical school, how that how that actually guided me and and the perspectives that I had.

DR. STRIKER:

It seems to me that a lot of individuals who come from families who were not able to go go to either complete school or get advanced degrees or education and and in fact, sacrificed quite a bit for their children to do so, tend to go into areas that give back to public health, if you will, or concentrate more on public health or groups or giving back to the community. You know, and to some extent, we all do as physicians. But is there something to that where when you come from a background like I just described, that you're more apt to give back to the community at large?

DR. LUCERO:

Yeah. I mean, of course, I obviously have thought about that from the perspective of health care and the place that I sit in in admissions for medical school. I see that a lot. I think time and time again you read and talk to the students that are writing their personal statements and talking to the students that are medical students or even in interviews. And you hear about their experiences, not dissimilar to mine. And and sadly, I think it's concerning because it makes me think about we haven't changed and we're still consistently having the same issues despite the time that's happened and all that we have been trying to do. But I think the studies have shown that individuals who come from communities that have been marginalized, those students then become physicians and those physicians go back and care for those communities. And caring for those communities can be a lot of different things, whether they're doing public health, research, policy, doing the work that I do in diversifying the physician workforce and educating faculty and students and residents on the importance of that and the historical perspectives. I think we feel there is this need because we're trying to make that change because we have what's been set up as this structural racism and we've experienced it in all of our lived experiences with our family.

DR. STRIKER:

Well, let's talk about that a little bit. You address this in a New England Journal of Medicine article last year, but you use the term aversive racism. Can you explain what that is and how it differs from structural racism and also how it intersects with implicit bias?

DR. LUCERO:

Yeah, sure. So I think to talk about this, we have to sort of start from the perspective of that there is an existing group based hierarchy within society. We sort of divide individuals up and there is those that are in power and that make decisions and we call that the dominant group. And then we have the groups that fall below and they can be in different orders. But they they definitely are the individuals that don't hold the power that society deems is important. And so when you think about starting from that frame of reference and how societies continue to perpetuate this social dominance theory is what I'm describing, this group based hierarchy, they do that through the various concepts of legitimizing myths. And so we always hear about if you just work hard, you'll get the the benefits of society, the idea of people being self-made. All of those ideas, these legitimizing myths, are what help continue to hold this group-based hierarchy in place.

And when you think about that, you also have these groups. There's in groups and out groups, and I describe it the easiest way to describe it is when you think about sports teams. And so I'm from LA and I also previously worked in San Francisco. And so when you think of sports teams, there's the Dodgers versus the Giants and there's this Cross California rivalry. And you're either a Dodger fan or you're a Giants fan. And the way we think about in-group favoritism and this in-group bias is we tend to like the people that are part of our group. How we define that group depends. Right? So we may define our group by our sports fans. I'm a Dodger fan. I like other Dodger fans. And we're great people. And we do great things and we're smart and were bright. And those Giants fans, you know, they're not they're not as smart or bright. And if the Giants fans do something, like cut in front of us in line at the stadium, we give that that cutting in line, it's because they're unethical. They they're trying to cheat their way. But if a Dodger fan cuts in the line, we give another reason for that, which is, oh, they probably didn't see where the line was. And those are the sort of in-group favoritism that we tend to hold. And it helps support this this hierarchy. So I tend to, you know, we have it with the Harvard and the Yale. We continue to perpetuate the Harvard and Yale rivalry. It's tongue in cheek. But this goes deeper. It goes deeper as we start to look at different racial communities, different areas of where you live, different schools that you go to, access to different things, and then you take it into the health care system and where you come from, where you grew up, what where you went to school, how that is seen, and how in-group favoritism works. And in that, we also have what is our implicit bias. And so we talk about that and that's been talked about a lot in health care and everybody's talked about doing the Harvard IAT and where you see what your bias is for race. They have all different itis, but we've looked a lot about black versus white and your preference, your implicit so unknowing to you unconsciously you have a preference for one group over another. And how that works its way into manifesting itself as aversive racism is it allows for progressive, well-meaning, intellectual folks, those that are college educated, those that are physicians, highly educated, it allows them to act in a similar way as an overt racist is but truly believe they're not racist. So in

other words, they may make a decision or take an action that to them they give a non-racist, reasonable explanation of their action. They don't actually know they're doing this because it's it's part of their unconscious bias.

So when we think about how this happens, it happens many times, in part of the article that I wrote, we had quotes of actual quotes of what people have said, for example, things like we value diversity, but we want qualified people. And so when you think about what that person is saying, it is a comment that is steeped in putting together this quality and diversity are you can't have both, right? Or using something else like they're kind of over the top or they're they just need to to, to be less abrasive. There's all these different comments that are made that sort of give this idea that it has nothing to do with the person's race or ethnicity, but it's more about another action. And so that is steeped in this unconscious bias that we have and in this in-group favoritism. And it allows us to have this disparate treatment of our patients, disparate treatment of our students, of our learners, and of our faculty.

DR. STRIKER:

Well do you think some of that skepticism comes from, from a point of view, that creating workforces that are more diverse, because that's the goal, is just to create diversity for its own sake, we've had conversations on this podcast before with a lot of experts on this area and make compelling arguments for why we need a diverse workforce. But I feel like that message is not getting through to everybody, the real the benefits or the reasons for creating the diverse workforce in the first place.

DR. LUCERO:

Yeah, I think I understand what you're saying, you know first you have to acknowledge that there's a hierarchy. So when people say, well, it's maybe they aren't as qualified, I always like to give the example and this comes up a lot when when we mention the term affirmative action, you know. I've heard faculty say, well, if we if we have affirmative action, we're having less qualified people. And so I always give the example of when I was at medical school, my graduation, which was a big day for for me and for my family and my community. And we as a community and as my family overcame a lot to really sort of have me sit in that space at an institution that historically did not accept my community. And we never got to walk through those gates. And so as we sat there, it was a big event because it was the 300th anniversary of the institution, of Yale University being there and established. And so normally they don't have a graduation day speaker But because of this they did. And they had the current president at the time, which was George Bush. And he stood up in front of the group. And there my family was in the back and, and as was all other families. And in his speech, he talked

about, here I am an example of even a C student can become president of the United States. And for us to hear that and to think about what that meant, it was essentially saying, *I* can be a C student, but you can't be the C student. So when I think about when people talk about, well, maybe they're not as qualified, how are we defining that? That's the issue. How do we define? And the definitions of what quality? What is someone that deserves to be at a spot that that idea of deserving or what we're looking at, what metrics that we're following. You know, by the metrics that they looked at of this individual, they had no issue bringing him in as a C student. But me or my family would never have that same judgment with those metrics. We had to do more. And historically that is always been the case. We already start behind. We already start with environments where the quality of the schools, the environment, the pollutants, the places where we live, we're already behind. And with all of the resources, an individual like the graduation speaker who had C grades was able to get into one of the most prestigious institutions. And so how is that equitable?

And I think that sort of goes into this idea of you have these this group-based hierarchy, and it is supported by these legitimizing myths. You know, this individual believes that they earned it believes that. And we've heard it from from other presidents that they were self-made. Well, when you look at it, nobody's self-made. We all have I I personally have had the benefits of my father working two jobs and instilling in me the need to continue to persevere. I would never say that I was self-made. None of us are. But that idea that you can pull yourself up from your bootstraps, that's a concept that for individuals who are in the dominant group, they continue to support that. And when it comes down to it, it is inequitable.

And so when we think about how we measure or value or say what is going to make a phenomenal medical student, a phenomenal doctor, someone that is going to diversify the workforce. If we're measuring it by looking at the sheer health disparities that we have and what those, who are experiencing those what communities are experiencing them. Then we have to ask ourselves, I think we need to have people from those communities to come. And that's a metric that we should be looking at. Because we're not going to make an impact in these terrible statistics unless we have people from that community who the community trusts and understands and that they will listen to, because historically, those in those marginalized communities have never been heard by the dominant group.

DR. STRIKER:

Well, let's talk a little bit more specifically. You touched on this already, but health care and faculty in academia, oftentimes there's this perception that we feel, oh, we're above all this, we're progressive. We can't be like that. I want to if you don't mind, just delving a

little bit more into that aspect, whether we give ourselves too much credit and what our blind spots are.

DR. LUCERO:

Yeah, absolutely. I think, you know, academic medicine and as you mentioned, you know, all individuals of college educated, elite individuals, progressives, CEOs, all of us were all part of this society. We all experience it in the same way. So we're never above it. You know, when I walk out of my office and walk onto the street, I'm I'm a regular person. I experience and see the world in the way that I have from my lived experience. So, you know, to think that we're above it is is what does great harm.

And I think when we look at academic medicine, you know, the question really becomes, are we looking at it from this lens of of this hierarchy? And as I mentioned, the measurements of how we look at things. We think about leadership. Right. What what makes a great leader. There's a lot of different factors that make a great leader. And when you're starting to choose an academic chair, for example, or a dean of a medical school, there's a lot of different, very qualified individuals. They all don't have the same qualities. And you're choosing based on some ambiguous criteria that you decide sort of makes a good leader. And this is where we get into this, the complexity of where in-group favoritism can can really impact our choices because we want to be comfortable around that person. We want to we know if we're if we're the leader and we're choosing somebody, if I'm a dean and I'm looking at who's going to be the chair of a department, anesthesia, for example, I'm going to be interacting with this person. I'm going to want to see that I'm comfortable with that person. And we don't even know that we're sort of thinking about it that way. And it has shown and I mean, aversive racism is lots of papers that have been done in studies, in social psychology, that look at the amount of time that an individual spends as a physician, a white physician taking care of a black patient, the amount of eye contact, the amount of time they spend versus a white patient. And those are all these like subtle little things that we think about. They're unconscious to us. But, you know, that sort of I think they're a good fit. I have a good feeling about this person. It's all based on our comfort of that. And when we're choosing leaders, we think about those leaders in relation to us as the person that's going to make that choice or that committee that's going to make that choice. So in order for us to have diversifying the leadership, we have to have a community that's not just one group of people or that comes from one set of training or that comes from one university. They can't just be all one race and ethnicity. We have to really have that diverse group that also feels comfortable around an individual who's a black man or an Asian woman or a Native American woman. We have to have that diversity in order to get at and chip away at these these implicit biases and the aversive of racism that we

that we see globally. It's not just in academics, and we're absolutely not above it in academics.

DR. STRIKER:

Well, my next question is, how do we fix it? And before we get there, because that's an important we're going to talk about solutions here in just a little bit. I don't want to gloss over an important aspect of all this, which is the health disparity aspect. And I just want to spend a minute or two telling our listeners where you see the health disparities in anesthesia specifically and how racism and marginalization hurts the workforce. But but also really more importantly, even our patients.

DR. LUCERO:

Yeah, definitely. It's a really critical and it's it's kind of why we're talking about all of the issues around diversifying the workforce. I think my perspective is I trained as an obstetrician gynecologist and practice for two years and then came back and did anesthesia and, did an OB anesthesia fellowship. And, and my focus has been in obstetric anesthesia and it has its fair share of health disparities. And so when we think about it there, black women are 3 to 4 times more likely to have mortality event in and morbidities within obstetrics compared to their white counterparts. And Native American women, very similar statistics -- three times more likely to die in childbirth compared to the white community. And I think looking at those numbers, the initial idea was, well, there's probably co-morbidities. They have higher hypertension, diabetes, all of these things were cited, socioeconomic status, etc.. And study after study has come out controlling for those factors and showing that it's actually something more than that. And the part that we feel uncomfortable hearing is it's something else. And that's something else is what we've been talking about, the concept of aversive racism, disparate treatment. And historically, we have we have seen that. So. You have a group of physicians who don't realize that they may be engaging in disparate care and clearly are because the numbers don't lie. And then you have on top of that, a group of individuals who come from historically marginalized communities, who have experienced, and families have experienced, atrocities perpetuated by the medical community. Examples in in women's health have been the forced sterilization of Native American women, of Mexican women, of our prison populations, either coerced or forced or unknown and documented. And that's one aspect. There's been other aspects where studies have been done, where cells have been taken and consents haven't been done, and just endless amounts. We always hear about the Tuskegee Trials is another major one, but there are so many. And in obstetrics, there's a sordid past of what was done to black women historically.

And many of these things, we think about them as far, far in the past, and they're not. These have been happening as recently as the nineties. And there is this incredible distrust and and for good reason, because we know about these events that have happened. And so when you have that collision of this bias and aversive racism perpetuated by the physician community, this historical perspective of mistreatment, and those two things come together, you have patients that are uncomfortable and untrusting and physicians that don't realize that they're not hearing and seeing these patients in the same way that they hear and see and care for their white patients. That's where you see these health disparities. And it's been documented. These concepts of of aversive racism documented when you look at the outcomes. And so how do we improve that? Well, one of the fastest ways that we can improve that is obviously diversifying the workforce and creating an environment where you have patients being cared for by people from their community. And it simultaneously you need to be educating the current physician workforce on how these factors impact their delivery of care to these patients.

DR. STRIKER:

Well, I want to continue talking about solutions, but let's take a short patient safety break. So if you don't mind, just please stay with me.

(MUSIC)

DR. KEITH RUSKIN:

Hi, this is Dr. Keith Ruskin with the ASA Patient Safety editorial board. Anesthesiologists who rely on physiologic monitors, ventilators and other medical equipment to alert them to potentially life threatening conditions and provide vital life support functions. But alarm fatigue can cause clinicians to ignore alarms. Optimizing your monitor settings will make signals like an electrocardiogram, tracing or pulse oximetry more useful and improve the reliability of any alarms. And although conventional wisdom suggests setting alarms as loud as possible to attract attention, reducing the volume for alarms that do not indicate a life-threatening condition can reduce the noise level without jeopardizing alarm responsiveness. If an alarm is activated, verbally acknowledge it and then silence it while addressing the problem that triggered the alarm. These simple changes can help to improve the accuracy of alarms and mitigate the effects of alarm fatigue.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. STRIKER:

Welcome back. Let's talk a little bit more about solutions. How can anesthesiologists and anesthesia leaders specifically begin to both acknowledge and also change the role of aversive racism within our departments and in the academic spaces we occupy more broadly? You've already mentioned educating yourself on concepts. What else can we do?

DR. LUCERO:

Yeah, absolutely. So you mentioned obviously educating ourselves on the concepts and I think we've been doing that across the academic communities and and understanding and hearing talks in professional conferences and such. I think some, some real other really very tangible items are, I mentioned a few of the historical issues, but understanding the perspective of these different communities historically when you read about and really understand, we didn't learn a lot about it in medical school when I was a student, I think the only thing we heard about was the Tuskegee trial, and we didn't really learn about all of the different aspects of of where this this mistrust and the historical concepts of where these these are coming from.

I think the other part of it is when you think about the concept of of in-group versus outgroup and widening our in-group, we think about looking at who's our community, who are we hanging out with, who are we talking to? Medicine is a team sport. It's collaborative, and we can always see how we go into our silos. The surgeons on one side, the anesthesiologists on the other, the nurses somewhere else, the the anesthesia techs, another. That's that's a way in which we can see in patient safety that impacts the safety of the patient. Now, you add on the concepts of of aversive racism and our implicit bias, and you can see how that is going to have a recipe for disaster on the patient care side. So creating a more team and collaborative, broadening our our in-group, and thinking about it in that way. And when we look at especially for our academic physicians, we need to think about how we can bring in larger, diverse communities in our workforce. And how do we educate them? It's not just bringing someone, you know, we talk about diversity and we talk about inclusion, right? We need to bring individuals into these spaces, but we actually have to include them. And we have to use our education to educate equally. And when we're making evaluations, we have to understand the role that that bias plays in even our evaluations of different students and of different residents. We talk about this concept of holistic review, and I think that has been talked about a lot in medical school admissions. It's making its way into graduate medical education and looking at our our residents and fellows. But we need to think about that in our leadership decisions and our faculty decisions. We have

to holistically look at someone and see everything about them and where they come from in their lived experience and what they bring. And not just look at it by three different metrics. And then our leaders need to really understand and embrace this. I always tell, in our faculty, when we're looking broadly across the different specialties, I always make the comment to choose your chairs wisely. Because a chair has a really impactful way to be able to lead and move these concepts along. Even for individuals who may be reticent, the chair can have a huge impact and we can see how we can make major progress when the leadership not just says they're doing it or is performative about it, but when they really embrace it and understand it.

DR. STRIKER:

Well, you've explained what marginalization looks like. What about allyship? What makes a good ally?

DR. LUCERO:

Yeah, allyship is again another concept that has been talked about a lot. And I think being a good ally, it's subtle, right? So if someone is is going to be an ally, it's really not about that person. They're doing it for the person that has experienced a microaggression, an aversive racist act, who's been marginalized in a in a situation. And they need to step up. And the person that is an ally often is the person that holds that power, and we think about the group based hierarchy, they're often, in our group based how we have a very white dominant group based hierarchy, right? So I think if it's a for example, a white male holds a lot of power in our society. And so for them to be an ally, it means for them to acknowledge that a microaggression, for example, has happened and then respond to that comment. And also that shows that they are really being an ally to the person that had to experience that comment and also shows that they are stepping up and not tolerating that environment. But it can't just be about that person. They have to empower the individual who received that. So it's not just about the person stepping up and feeling good that they did that. It can't be performative. The center is not the person that's being the ally. The center is the event that happened and how that fell onto the individual who received it. And it can be very powerful in stopping these aversive racist acts, these microaggressions.

And it's so important that one of the things that the LNA community, so our black Latinx and Native American community in at UCLA, for example, had asked is they said it's it's important for an ally to step up in that moment, not secretly text them after and said, say, I agree with you on this. And we've all had those experiences where a person who's from a marginalized community has stepped up and said something, and when they do that, they're putting their self on the line. When you think about the group-based

hierarchy, they're really putting their self in, not being deferential to this dominant group and saying something. And if they're someone else from the dominant group that wants to be an ally, being an ally is not two days later or the next day sending a text message or emailing saying, Hey, I totally agree with what you said. Being an ally is saying I absolutely agree right then and there and putting their self out there to agree with that person. That's that's allyship.

DR. STRIKER:

I'm sure you see the performative aspect quite a bit. But in your experience, is it pretty rare to see substantive intervention versus just performative?

DR. LUCERO:

It's a great question. Right now, I think within academic medicine, I think there's a lot more performative happening than substantive. I think I've been pleasantly surprised by individuals. They're often individuals that from their race perspective, they're in the dominant group. So they're a white male. But but they maybe have an understanding because there are first generations at college. So there is that understanding of marginalization in that experience of being othered. And and they tend to be the ones that I've actually been pleasantly surprised that have stepped up and spoken out and have taken on something that could, as they hold a leadership position, and it may be they're new in that position, they're still sort of vulnerable from that leadership, they are still doing the right thing and taking on that mission to ally with with an individual or over an event or something that is really going to be impactful. But they're putting themselves on the line. And so I unfortunately haven't seen it as much as I would like. We talk about power and privilege, and in academic medicine, the leadership and the the title and the position that you hold is, is it's about power. It's about power and having that. And if you care too much about it, you tend to to be performative just to sort of look as if you care. But if you don't care as much, you tend to make substantive differences and that's impactful.

DR. STRIKER:

Well, before I let you go, do you have a call to action for our anesthesia colleagues? What can we all do? Even ones not in leadership or formal positions of power? What can we do in our day to day lives to become more intentional about examining our own biases and making choices that lead to these improvements we've been talking about, even when it's uncomfortable?

DR. LUCERO:

Yeah, I think obviously we're it's always about education, right? So physicians are are are always educating themselves. We're always going to continuing medical education. We're reading. We're reviewing abstracts, journals. We need to make this a priority as well and educating ourselves on these concepts. So that's really something that we may not have learned it in school. That's not we learned the Krebs cycle. It's now time for us to learn about about these concepts. We can't deny or overlook what we're seeing once we're educated. So I always say when you read about this and learn about the data, the concepts, what we're looking at, when you read about a verse of racism, you can't unsee it. Once you see it, you can't unsee it and it's there. And and I think that the most important thing and why I love medicine so much is it's this intersection of science and humanity. We are first and foremost human. What we're doing in caring for our patients day to day is going to have impact on these these patients. And as I read many personal statements from medical student applicants, they all have this underlying theme of altruism. So we need to really embrace that and not forget that as as physicians, it's obviously thinking about to to heal a person, to care for them, to repair the fracture, to take the pain away. But we also need to uplift them and give them equal footing. And I think it's really imperative for our practicing physicians, our academic physicians, anyone who's engaging in health care with the patients to really understand that, remind ourselves of that. One of my mentors said to me, Go back to your personal statement for medical school and read what you wrote. And I think if we all did that we would understand why we went into medicine. And to think about that is really important when we're caring for our diverse patient populations and treating them all in the way that we would want to be treated or we want our family to be treated.

DR. STRIKER:

Well, it’s well stated. This is an incredibly important topic and we appreciate you dropping by to share your experiences, your expertise, and certainly value your input. And I just want to thank you for joining us.

DR. LUCERO:

Thank you for having me.

DR. STRIKER:

And also I want to thank our listeners. Please don't forget to follow and review and join us for the next episode of Central Line wherever you get your podcasts. Take care.

(SOUNDBITE OF MUSIC)

VOICE OVER:

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