A Day Away Podcast with Alison Smith and Dr. Jesse Guscott

Alison Smith: Welcome to *A Day Away* where we chat about the planning, building and funding of South Georgian Bay's Hospital of Tomorrow. My name is Alison Smith and I'm the Director of Communications for the CGMH Foundation and newly appointed podcast host. I'm a huge fan of the podcast medium, as I think it really allows for deeper conversations and learning and is really helpful for those on the go. My fun podcast fact about me is that I once travelled to Washington, DC to watch a live recording of the NPR politics podcast.

We are exploring topics centred around CGMH's innovation, collaborative spirit and the importance of rural medicine. Our hope is that we can inform our community on the impact of your support and how you play such a vital role in the future of healthcare.

Today I'm speaking with Dr. Guscott, Rural Generalist and award-winning Medical Educator for CGMH. Dr. Guscott had a vision for CGMH to be a leader in training and education. He proposed a training program based on medical simulations specific to rural environments and the challenges particular to rural medicine. His vision was to build the program specific to CGMH needs and then market the program with other rural healthcare providers, to create a revenue source to sustain the simulation program long term.

CGMH is an 84-bed hospital located in Collingwood, Ontario, serving more than 73,000 permanent residents and 3.5 million annual visitors to the communities of Wasaga Beach, Collingwood, Clearview, The Blue Mountains, and parts of Grey Highlands.

Welcome, Dr. Guscott, and thank you so much for joining us today.

Dr. Jesse Guscott: Thank you, Alison.

Alison Smith: Before we dive into the conversation around CGMH, can you tell us a little bit about what brought you to Collingwood?

Dr. Jesse Guscott: Sure. I went to medical school in Hamilton. I did my undergraduate in Vancouver. Then when I was in Hamilton, there's a stage of medical training called clinical clerkship, where basically, classrooms are done. You get out into clinical rotations and you're starting to learn on the spot. There was an opportunity in my class to do our clerkships outside of town. It was kind of a funny thing. It's much more common now, but at the time it was very uncommon. But my class and the class ahead of me had sort of a double cohort because they were changing schedules around. So, they were looking for people to get out into the community because they didn't really have capacity in Hamilton. There was this opportunity to come to Collingwood. I'll be honest, there were some great perks. They rented us a condo to stay at, gave us a ski pass to ski at Blue Mountain, and I thought that sounds fantastic. I could go do my family medicine rotation next to the ski hill. So, as a clerk, I came up and did a rotation here. I just truly fell in love with the medicine. I worked with some really amazing physicians in the community, and because my training up to that point had all been in the city, all been in Hamilton, I had never experienced it, had no sense of what physicians and healthcare teams in communities really look like. And I just fell in love with it. I thought it was so cool. The idea of generalism, the idea that you don't have to be super specialized, that you can do a lot of different things, just really appealed to me. Watching how skilled some of my mentors were, I just thought ‘That's it! That's what I want to do. That's the kind of medicine that I want to do.’ I went on to train in

a residency program that was also in Collingwood, brand new. McMaster had a rural family medicine residency program. I was the second resident through that program. Then I ended up here for the better part of 2 and 1/2 years, went back and did a fellowship in anesthesia, and then I was basically looking for a community that matched my residency experience. I was trying to find a community just like Collingwood and at some point I thought why am I trying to find a place just like Collingwood? Why don't I just go back to Collingwood? So that kind of, you know, that's how it all sort of unfolded. I think my experience as a learner really framed what I was looking for in a future practice and Collingwood was the place. I would say as much as the community is amazing, the ski hill is amazing, all those other things, for me it was really the medicine, you know, and the hospital community was the biggest thing that drew me here.

Alison Smith: Well, that's great. We're definitely going to talk a little bit about the general practice and also the challenges facing rural communities. I think across the province right now, we see a range of disparities in resources, technology, equipment, that really impact the provision of services and quality of care that patients receive.

Through your simulation training program, you are looking to equip healthcare providers and provide equitable healthcare outcomes. Can you tell us a bit about the program for people that aren't familiar with it and why it's so vital for a rural hospital like ours?

Dr. Jesse Guscott: I'd love to. The program that I run is a simulation program. The easiest analogy would be to think about a flight simulator for pilots. You don't want the first time you're ever in a terrible emergency to be the time that you're actually in a terrible emergency.

Pilots get put into flight simulators. They run through the predictable scenarios, dangerous scenarios, things that, you know,

hopefully will never encounter in your life, but if you do, maybe it's once and you want to perform optimally.

Our simulation program tries to take some of those same elements and train healthcare professionals in that sort of a setting. We're not practicing the sprained ankles and the coughs and colds. We're practicing the things that happen only occasionally, that are very dangerous, that are very high stakes, where decision-making, communication, leadership in the moment, is going to make a difference in patient outcomes. We have a number of different branches of our simulation program, but we'll do things like adult cardiac arrests on the ward, where we want to practice our responses to an unexpected cardiac arrest. We have a program for neonatal resuscitation, where we practice what happens when a baby comes out and they're struggling in their first minutes. We have pediatric programs. We have an OR program. We kind of try to hit all the different parts of the hospital and focus on those emergencies that we don't see every day and want to perform optimally in.

Alison Smith: I have heard you talk about the parallels between the airline industry before, including where the majority of crisis and emergencies involve maybe failures of leadership, decision-making, communication, but what originally drew you to the airline industry? How were you able to create that parallel?

Dr. Jesse Guscott: I think that's fundamentally where simulation in medicine has come from. The airline industry got out to a head start in the '60s and '70s in response to a safety record that was suboptimal. The airline industry really looked at how can we train people to do better. What they found was it wasn't always purely technical issues. It wasn't always purely mechanical issues. It wasn't planes exploding in the sky. It would be a landing gear malfunctions or one of the engines is down, but they still have a fully functional engine. If they respond extremely well as a team, lots of those

scenarios would be salvageable. But when the leadership breaks down, when the communication breaks down, when the decision-making breaks down, that's what ultimately leads to bad outcomes.

Medicine came into that game having seen other industries do that. Anesthesia, which is where most of my clinical practice is, is the branch of medicine that does it the most. And again, it has the best parallels to the airline industry in that it's very technical. Anesthesia is like a lot of monitors and beeping things, and we spend a lot of time watching our screen in addition to our patient. It's easy to simulate bad things because you make bad things happen on monitors much like you could do in the cockpit of a flight simulator. Anesthesia was kind of like the first branch of medicine that really got into it and then it's expanded out, into essentially all the other branches of clinical medicine. That's how I got involved in it.

I run the family practice anesthesia residency training program for McMaster and got invited to participate in a simulation day, I want to say in 2010, in Sudbury, and went up there and watched what was happening there and thought it was just the coolest thing and thought I want to do that and I want to keep doing that. That was sort of where I got started to get involved in simulation and after I had done that for a number of years in Sudbury I started to think ‘why aren't we doing this in Collingwood?’ We've got a lot of the tools and the resources to be leaders in simulation education. I think Collingwood is already a leader, has been for a long time, a leader in rural education, medical education. I thought we're perfectly suited to develop a program.

Alison Smith: Now since 2010, so many years have passed that you've been working on this program and growing and expanding it. How are you finding it's impacting the retention of people that go through the program, but also recruitment?

Dr. Jesse Guscott: Yeah, I can think of some really concrete examples. I think the narrative that I get told all the time is 'these sessions make me feel more comfortable. These sessions make me feel safer. Make me feel like I know what I'm doing. Make me feel more confident.' And I think that's such a huge part of retention in smaller communities. When we're in smaller communities, we don't have the luxury of calling the subspecialists for a lot of things that in the city that would typically happen, so we ask more of our generalists. We ask our nurses to look after more clinical scenarios than they might have to in the city, we ask our family physicians to resuscitate newborns, where in the city that would be a pediatrician that does that. So, if we're going to ask more of our staff, of our faculty, we have to provide them the tools to be able to do that.

The narrative that I get told is, you know, come out of a 1-hour refresher on Neonatal simulation, people will thank our team and tell us how much more confident that makes them feel. I can give you a retention example again in the neonate's unit. There was a point in time where the number of physicians that were looking after neonates had dwindled down to two people. You can't sustain a program with two people because that meant they were on call every other night and that just isn't sustainable, and people are going to burn out. So, what we did was we really focused on education to anybody who might be interested and a lot of people said 'well, I just don't feel confident enough in that medicine to be part of that team'. So, we really focused our education on those physicians, and I think have built that team up to 14 or 16 physicians who now with the confidence of having some simulation, having some regular practice once a month we get together for a half day and offer that training. Then confidence isn't the piece that gets people out. So, I think with all of the things where we're asking people to do a little more than they might have to in other clinical scenarios, having the confidence, the skills, the experience helps to both recruit and retain physicians.

Alison Smith: I think that's pretty remarkable going from two to sixteen. I mean, I think that would just give our community more confidence in general as well, knowing that that is such a robust team that feels good about those scenarios.

Dr. Jesse Guscott: Yeah. I think also Alison, the really important piece of that, of increasing that number, is that it's sustainable. When you have 16, then you're not asking two people to shoulder all of the burden. And I think you can keep those 16 in that role for much longer.

Whereas if you have two or four or six, they're going to burn themselves out. There's only so long you can do that kind of work. And being able to build up a number that's sustainable, I think has been a really proud achievement for our simulation program.

Alison Smith: Absolutely. Another, proud achievement as well, is a very specific example I'd like to talk about. So, we know that our hospital has a proven track record of navigating rural trauma care with expertise and efficiency. And maybe one of our most extreme examples of impact would be a head-on collision in 2018 where CGMH staff along with CritiCall, which is the organization who supports acute care hospitals when coordinated emergency and disaster response is required, along with Ornge, the air ambulance service, coordinated the single largest deployment event of paramedics, helicopters, fixed-wing aircraft, and land ambulance crews in the province's history. Can you tell us a bit about that day and how simulation training really plays such a vital role in such an extreme situation like that?

Dr. Jesse Guscott: Yeah, I'll never forget that day.

So, I was doing my clinical medicine, which is anesthesia primarily right now, and I was giving sedations for colonoscopies that day, which is generally not a super exciting, stressful day. It's pretty

routine. We do sometimes 20 scopes in a day and I was in my groove, not having a very stressful day. We were getting really close to the end of the day. We're in our last couple of patients and I remember hearing Code Orange paged overhead and it took me a minute. You never hear that. That's not a code overhead page that we ever hear. And I think that was probably the first time I ever heard it. So, it took our team all a minute to 30 seconds to kind of even remember what that was. I called up to the emergency room to see if it was a fire drill or if it was a real thing and if they wanted me to come and I could tell by the urgency of the voice on the other end of the phone that they wanted me there very quickly.

So, I ran upstairs, and it was like a scene of absolute chaos. There were over 100 people in that department for sure. There were ambulance and police and firefighters. When a Code Orange is called basically everyone mobilizes. So, we have not only clinical teams, but the CEO is there, the VPs are there. Basically, everybody is in that department.

The thing I remember most, Alison, was I could hear this wailing. I could hear a kid wailing over all of the other sounds of the department and I just went in that direction. Felt like that was probably where I should go. I came in and there was a kid who was horrifically injured. The injuries were really horrible. So, I focused my attention there. That's a comfortable spot for me. That's the kind of work that we practice is the really sick patients and being able to draw from the simulation, the education experience. Once you can get settled and start to feel like this is a thing you know, that's the best part. That's when it starts to feel a little more comfortable.

The chaos of the noise and the people, that's disorienting. And so, I think once I was able to get into a room with a patient, get stock of my team, that was a really big piece too. These were not familiar because we had called everybody in, physicians were literally coming from the ski hill, coming from their offices. They weren't familiar teams. It wasn't like you look to your right and

you're like, "Oh, that's the person that I normally would do this with." I think I was resuscitating this child with a family physician. There were obstetricians in the department. Basically, everyone was there to help. So, my simulation training and work, a lot of that is around taking stock of your resources and getting the most out of your resources. Everybody has something to offer. Everybody has a skill set. And so, just looking around the room and figuring out what the skill sets are of the people that were in the room. I would say that was probably the biggest application of the simulation training that I have and simulation experience that I have.

So, we were able to rally, and that child needed a breathing tube, they had some really horrific fractures that needed to be pulled out to length, needed to be transferred to SickKids. We suspected they had a serious head injury. So, I got all of that organized for that child and then there were so many patients that you basically just went down the line. Once that child was packaged and in a reasonable position to get transferred out, I left them in the care of one of the family physicians and then moved on to the next one who needed a breathing tube.

I can't remember the numbers off the top of my head, but I want to say six or eight people ended up intubated. I think we transferred out about 10. The crazy part is the kids all went to SickKids and SickKids, which is the biggest pediatric hospital in the country obviously, and one of the biggest in North America, they had a Code Orange. So, they called a Code Orange for the kids that came to our department. We feel like we're overwhelmed with this stuff but Toronto was overwhelmed and they were taking just the pediatric patients. We had adult patients as well.

It was a really proud moment. I think our hospital did really well. I got some really amazing feedback through some professional contacts. One of the anesthesiologists who happened to be on call at SickKids, fed back to me that when those kids got there, everyone was so impressed with how they were packaged. One of my former residents actually texted me and said it was a little

anticlimactic because they were all geared up to have to do all these things and the kids showed up just as well packaged as they could be.

That's a long story, but that was definitely a moment that you could hear a little bit of PTSD in my voice probably. That was a big day for us. Upsetting, hard to see these kids struggling, but a proud moment for our hospital and our organization in how we rallied and responded to that.

Alison Smith: Absolutely. I think as a community member, we heard a bit about it in the news and maybe stories through friends and colleagues and whatnot, but to have been there on that day, I can't imagine how remarkable that was and how scary.

I always think about that with simulation training, when it comes to the real situation versus practicing it, what that must actually feel like. It sounds like through the simulation program, you are preparing people for that moment to be able to block out that noise, block out that anxiety, and be able to handle the situation adequately.

Dr. Jesse Guscott: Yeah, I think that's a big piece. We talk about fidelity or realism in simulation. Why do we go to all these efforts to make things feel so real? And I just want to segue for one second, Alison, to just acknowledge that I'm here talking on behalf of the simulation team, but I am a mere small piece of what is a really incredible team. None of this happens just for me and it all could probably happen without me, but we have an amazing team and that team, one of the things we really focus on is trying to create realism.

What that means is we might have scenarios, if we're resuscitating a kid, we might have a scenario where the mother just appears and is in the room and now you have to handle not only this child

but also the stress of having mom in the room and her emotions bleeding in.

You'd be amazed at the acting skills of some of our doctors and nurses, and maybe for lots of us, it's pretty easy to play the role of a stressed-out parent because we experience that. But we need that energy in the room because a big part of what makes these scenarios so hard, is not just the technical piece, not just that your landing gear is not working, it's the fear of, for a pilot, 200 people's lives are in your hands. For a physician or a nurse or respiratory therapist, it's the stress of this little kid's life being in your hands. We want to embrace that. We want to try to recreate that a little bit, so that people see how they respond in that.

One of the things I challenge the participants to do is to pay attention to those feelings and to pay attention to how their brains respond when they're feeling stressed, when they're feeling emotional stress or psychological stress, because that's all part of it. We have to learn to manage that. We can't just make that go away. You can't snap your fingers and say, "Oh, just don't be stressed when these bad things happen." I think practicing it inoculates you a little bit to that stress, makes your heart rate go up a little less the next time you see it. But it's still going to go up. Your brain's still going to shrink. You're still going to feel these feelings. And simulation training is a lot about preparing yourself for that response, your own response, rather than just the things that are happening around you.

Alison Smith: The other big story, COVID. In spring 2020, before CGMH even received the first COVID positive patient, you knew that our doctors and clinical teams would need to be prepared for these worst-case scenarios that COVID would bring. Can you tell me a bit about how your teams developed and practiced simulation exercises to really treat those most vulnerable patients?

Dr. Jesse Guscott: Yeah, you're hitting at all my traumas.

Alison Smith: I know. I'm sorry. I'm sorry.

Dr. Jesse Guscott: It's okay. I'm just kidding. 2020 was an awful time for healthcare practitioners, for healthcare teams. We're just recovering. I think we like to not think about it for the most part, but it was a really tough time.

So, we knew bad things were happening. We knew bad things were happening in China and Italy and we were getting wind of serious impacts on big populations. And also, what was novel in that for us, was healthcare practitioners were getting really sick and healthcare practitioners were dying. Particularly in the stories coming out of Italy, a lot of the people who were caring for COVID patients were getting sick and dying.

It was a very stressful time for an educator because I really felt the weight of that responsibility, of we need to get this right. We need to figure out how to do this really well. I felt like the teams were depending on my simulation team, on me, on educators to tell them here's the safest way to do these things, here's how to protect yourself.

What we ended up simulating a lot of was putting breathing tubes in, which is called intubation, and that's how we, if you're getting on a life support system on a ventilator, you need a breathing tube as basically the conduit for that ventilator.

When patient's lungs are failing with really bad COVID, we need to prepare to do that. There was the thought at that time, that that was the most vulnerable time for healthcare practitioners because there's lots of germs in the air and you're getting your face right in the patient's face to put this breathing tube in. We focused a lot of our education attention then to 'What's the safest way to get that breathing tube in?' 'What's the sequence of events that's the

safest?' 'How do you do all of that in personal protective equipment that's very unfamiliar?'

Usually, when I'm intubating in the operating room, I've got my cloth hat and a mask on and my scrubs and that's about it. Here we were getting donned in hazmat suits trying to figure out what the safest suit was and what the safest mask was. All of it was super hot and super sweaty. How do you intubate when you kind of can't see because you're sweating into your goggles? So, that's kind of the work that we did. We tried to figure out what the safest equipment would be. We really hammered it down to I'm going to put my hand here and you're going to pass me this piece of equipment into my left hand and tried to do all of those things to make it really seamless. I think that helped to address the uncertainty of what was coming, to make sure that the first time we were intubating someone wasn't really the first time we were intubating someone. We had done that dozens of times on the mannequin, in a controlled fashion. And I think that allowed us to have something to draw on which ended up being really helpful.

Alison Smith: Well, I can say on behalf of our donors and patients, I know we were so grateful for you and the rest of the team during that time and every day since then and everything that you have been through.

Let's switch gears and talk about something that maybe feels a bit more positive and exciting and probably a little bit hopeful, and that's the new hospital.

I think you and your team have accomplished so much despite the challenges of this aging and cramped facility. But can you tell us a bit about the new simulation lab and how it will be equipped in the new hospital, and really the impact that it will have on care in our community?

Dr. Jesse Guscott: Yeah, that's way more fun.

Alison Smith: Exactly.

Dr. Jesse Guscott: Our simulation program right now, you know the space, Alison, we work out of what is essentially an oversized closet. We do an incredible amount of work with really, really limited space. We tend to draw from some clinical spaces. We tend to draw from some educational spaces that the Rural Ontario Medical Program lets us use. Just in the last year, we're starting to get some different spaces in the hospital, but we really have made do with very, very limited space.

Our vision for moving forward is much like what I got to see in Sudbury, which is a beautiful simulation lab that has multiple different spaces that are specifically designed for education. Right now, our space is an old operating room that was then an endoscopy suite, then was a storage room and is now a simulation room. And thinking about building a room from scratch, whose primary function is education just allows you to do some really interesting things. We've started to do that with some renovations in the hospital right now, where we have a space that we can use where we've put in a two-way mirror where you can have people sitting in a control room watching the simulation take place, in what feels like a separated place and the clinical team doesn't see you. Again, when we're talking about realism, that's one of the ways that you can create realism. Have it look and feel real and you're going to simulate some of those emotions and cognitive responses to stress. If you can see somebody in the corner typing on a computer and writing down notes about your performance, that takes away from the realism.

Being able to design a space where we can be physically slightly separated. Those spaces also get equipped with technology like cameras and microphones that allow us to interact with the simulated clinical space from a different room. So, that stuff's all

super exciting. We have some of it starting to roll out down the pipes now, but really looking forward to having a space that we design from the bottom up. I think it'll let us be able to do more.

Now we're sometimes challenged around there's just no space today to do a simulation. So, having education spaces that are pretty dedicated that we always have access to, I think will be really exciting. And then obviously the technology is super fun and being able to integrate that into our learning goals.

Alison Smith: Great. I think if I could just take a quick moment for our generous donors who have supported this program since its inception.

This community support has allowed our Sim team to purchase lifelike, very lifelike, teaching mannequins and build out an extensive library of high-stress challenging scenarios, simulating diagnosis and treatment of adults, children, and newborns in emergency situations.

The Sim team of medical professionals continues to grow and to share their expertise not just with the CGMH team but with medical personnel from across North America. As new medical challenges present themselves to CGMH, the Sim team will continue to use their skills and technology to improve responses to medical emergencies.

Our podcast is called *A Day Away* because we talk about tomorrow a lot around here. As a foundation, our work is always future planning and forward thinking to ensure we can provide and care for generations to come.

Today our community benefits from the generosity of those that gave before them. And now, we are embarking on our biggest and boldest mission yet, building South Georgian Bay's Hospital of Tomorrow.

We will expand healthcare services for our fast-growing community, improving patient care and privacy, helping to retain and recruit top healthcare professionals, and building on our strength in rural, interprofessional education and training.

We know that a bright, beautiful tomorrow is always possible because of the care that we take today. Hospitals are predicated on brighter tomorrows.

Dr. Guscott, thank you so much for sitting down with me today to talk about your work and to tell us a bit more about all that you do that is so vital and critical here at CGMH.

We like to end our sessions with some closing thoughts of what tomorrow means to you. It doesn't have to relate to CGMH, but more what you see for the health of our community and the future of South Georgian Bay.

Dr. Jesse Guscott: I think we're very well positioned. I think you've heard me say before, I think we 'punch above our weight class', you know, is a boxing analogy, but I think there's a lot of great things to be really proud about in our community. I think we have incredible healthcare teams. I think we have an incredible physician group. I think our leadership is excellent, and I think we're continuing to grow on those. So, I think for communities our size, the simulation program is just one of the examples of a thing that just doesn't happen in other communities of this size. I'm just proud to be one little piece of what is an amazing healthcare community.

Alison Smith: Your program has really benefited from the overwhelming generosity of our donors. Can you tell us a little bit about how they've really impacted your program?

Dr. Jesse Guscott: I would love to, Alison. Our program has been so fortunate to get some really visionary support from donors. Our equipment is very

expensive. A standard simulation mannequin runs around $100,000 and up and it needs toys and bells and whistles to make that work. That's why I always get offended when people call it a dummy because it's smarter than I am and very expensive.

Visionary donors who saw the need, understood the need, understood what we were trying to accomplish and were able to support us in some of that equipment purchase, but also hugely visionary around supporting the people that go into that.

What causes some simulation programs to fail is they get these very expensive pieces of equipment but no one to support it, no one to build the programs, no one to build the content, no one to teach the content. People can do that on a volunteer basis or for free for some period of time. But again, just like when we were talking about the Neonatal Resuscitation Program, you can't do all of that. You can't work super hard and do all of that in a small group, for free, for years on end.

Our programs are truly programs and not just mannequins that live in a closet. We've been supported to develop the programs, to develop the content, to keep teaching the sessions on a weekly and monthly basis. I can't say enough about how fortunate I feel to have donors that have been able to recognize the value of our program and let us build and let us expand and let us find ways to also generate some of our own funds to put back into the program. So, yeah, it's been really wonderful. I'm so thankful.

Alison Smith: Okay. I want to talk about the word rural. It's an interesting one, and I think one we talk about so much here and I think why I find it interesting is when I think of South Georgian Bay, it doesn't seem to fall into any of the categories. It's so unique, so different. I think we all feel so fortunate to live here.

But when we talk about rural medicine, it's actually really quite fascinating and what that can mean. Can you tell me about what

your definition of rural is and how it pertains to healthcare here in our community?

Dr. Jesse Guscott: Yeah, it's an interesting thing that I don't think about that often unless someone draws my attention to it, and in particular, Alison, I think some people are slighted by the idea of being rural, like it's an insult or a demeaning term about your community. But for me, and particularly around medicine, it's actually like a badge of honor.

Rural healthcare teams, for me, I'm super proud to be part of that. What it really means is a resource-limited setting. If you are in downtown Toronto, there is an Interventional Cardiologist within arm's length, within a baseball throw away, there's a Pediatrician just down the block. There is a Subspecialist Pediatrician who helps the Pediatrician on something that's really complicated. We don't have any of those things.

When we're talking about rural or resource limitations, all we're really saying is we don't have access to everything and we build systems and we build processes that accommodate for the fact that we don't have all of those things.

If you're in a hospital that has lots of Pediatricians, then Pediatricians form your neonatal response team. We don't have that here, so we build a different team that involves people who are specifically trained around that, whose background is family medicine, whose background is Obstetrical Nursing instead of Pediatrics and we build our own team. I'm super proud of that. I think that's super exciting and super fun. And I know how good the people who do those jobs are.

So, when I say rural or when I'm talking about being resource-limited, there's no piece of that that's a slight or an insult.

The term rural is probably not perfectly accurate to describe the geography of our community and I'll let other people come up with the definitions but just know that when people like me say

that word, it's not disparaging. It's actually a badge of honor. In my little bio you read, I describe myself as a Rural Generalist. That's the kind of medicine that I practice and I'm really proud of it. Anyone who also describes themselves that way, instantly gets respect from me because I know the challenges of the work that they do.

Alison Smith: It's really so fascinating to hear about rural medicine and really the constraints you face, but in fact, you're providing this excellent care that is just on par with other communities, because you were able to build these systems and processes. What else do you see as the strengths for rural medicine and practicing rural medicine here?

Dr. Jesse Guscott: I think the kinds of people that get drawn to rural medicine love these challenges. We love the opportunities to be Generalists, to do more, to more things. I think that's one of the strengths of being in a rural community is the people who are here, want to be here. They've chosen this environment. They've chosen to have these kinds of opportunities.

One of the reasons that I chose a community like this, part of it was, I practiced emergency medicine for 15 years. I do Hospitalist and patient medicine, so I like to do a lot of different things. I do some pain medicine, a bunch of different things, whatever excites me for a couple of years, I'll tend to latch on to. So, I enjoy that. I think lots of other people do that.

The other thing that I really loved about smaller communities, and maybe that's the word we want to use instead of rural, again, the semantics don't really matter to me, but in a smaller healthcare organization like this one, I really feel like I can affect change. I feel like if I was in a big hospital in Hamilton, where I trained, you see a problem and you know the solution, to try to get that change requires going to your Chief who goes to the MAC who goes to this Board and that Board and talks to these people and that

people and 6 months later, a year later, you're still talking about the same problem.

I just felt like here our leadership, our medical community, our medical administration, our medical staff are all leaner and more efficient. If I feel like I see a problem today, I can have that problem fixed by Tuesday. I can text the manager or the VP. I can text or call the CEO and just get things done quickly. And I really like that. I tend to gravitate towards leadership roles. But I do that here because I know I can affect change. If I was in a place where I just felt like I was up against bureaucracy all the time or had a million competing interests, I just wouldn't have the energy to be involved in leadership and I really love that opportunity here.

Alison Smith: I think we see the same thing as well even with donor support. The fact that we can be so nimble and maybe supporting a bit of that change. So, we have people that have been in the community their whole lives, multiple generations. We've had people that have moved up recently or are sometimes just here on weekends enjoying everything that South Georgian Bay has to offer. But no matter what, it seems like when there is a need in our community, our donors step up really quickly and get involved and help support us. So, I think that part has been so great to see as well through donor support.

Alison Smith: Thank you so much. We hope you enjoyed our conversation today. We are working to build the new hospital that South Georgian Bay needs and deserves.

With your help, our new facility will be ready to support all of us, when we need it most, when tomorrow comes.

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