A CONVERSATION WITH THOMAS H. LEE, MD

Physicians and Provider Organizers Should Ease Suffering, Invite Feedback

Interview by Peter Wehrwein

I’m curious about the genesis of the book. What prompted you to write it? You’ve known me in a variety of different contexts*, and this book actually was my attempt to tie it all together—all the things that I think, worry, talk, and write about related to making the health care system work.

How does the marketplace work? How do we make sure the marketplace is competing on the right things? That takes me into the Michael Porter stuff, the strategy of creation of value. What does value mean? It means meeting patients’ needs and doing it as efficiently as possible. That is the right thing, it’s a smart thing, but how do we actually do it?

I wanted to show that this stuff all fits together. It’s not the world gone mad. It’s actually “the world makes sense.”

And in that very last chapter, which is, like, five pages long, I tried to list those 10 things that are key steps that go from the very, very high, right on down to what kind of incentives I should be feeling when I’m sitting across from a patient.

I think it is impressive the way you knit together so many ideas. One of them is suffering and how health care should focus on relieving suffering. I squirm a little with the use of the word “suffering.” And in the book you talk about how you had reservations about it initially. It’s a word that makes people uncomfortable. We haven’t used it in health care until relatively recently. Now it’s being used more and more. I’d like to think that Press Ganey and I have something to do with that.

There are two things I would say. First, there has been so much medical progress, and we sort of break down problems and patients into narrower and narrower buckets where people with real expertise can bring the advance of science to people’s care. It’s progress that’s leading to that narrower focus. But now it’s easier to focus on a narrow problem than on the big picture. Second, there are so many distractions in life today. It’s important for me to look right at you when you’re a patient across from me, and muster the focus and the energy to think, “What is going on with him? What’s really important to him?”

But I think patients can really tell when physicians’ minds are wandering to other things. They’re flipping through papers, scrolling down a computer screen, glancing at their smartphones. So you need an idea like “suffering” to jar us into remembering to focus. The word is sensational. It commands attention. But that’s what we need to counter the distractions of modern life.

When you were getting trained, what word did people use instead of suffering? Everyone would use the same quote from Francis Peabody, which is, “The secret of the care of the patient is in caring for the patient.”

I don’t think that’s in the book. To me, it’s almost hard to say because it’s so obvious. It’s like “Do unto others as you would have them do unto you.”

Don’t you think suffering suggests passivity? Is that

*Lee was editor in chief of the Harvard Health Letter for several years while Wehrwein was editor.
a problem with this concept? I'm very aware of what you mean. It's like “cancer victim.” People don't want to be thought of as victims. The other thing I heard people say is, "Isn't suffering good? Doesn't suffering make you more noble?"

There's a sense that you're showing restraint when you suffer. And I hear that, and I respect where they're coming from. But as a rule, I'm against suffering. I would rather have less of it than more of it.

Let's shift to empathy. In the book, I think you're trying to bring suffering and empathy together. Empathy isn't about me feeling bad. It is about me doing the work to imagine what the patient is going through and what his needs are. Really looking at someone and understanding his context and what he needs—it's work. Empathy is a necessary step toward actually taking action to help reduce a patient’s suffering. And part of it is conveying that you understand his needs. Showing that, “Yeah, I get it, that it must be really tough, you know, and here are some things we can do, and if things aren't turning the corner by Saturday, call me, even though it's a Saturday.” That kind of thing.

There's a term that I like: "emotional labor." Empathy involves emotional labor. Most people in health care are hard workers. They’re ready to do work if you lay out the work for them. You can't make them better people than they are. They’re pretty good, but they’re human, so it's good news that you can work at being empathic.

In the book, you compare empathy to acting. When I first read about that I was turned off. Now, I recognize that when I'm walking into a room to see a patient—and I think I put this in the book—I will stand at the door for a second, take a deep breath, pull myself together, and I walk into the room and go, "Hi, I'm Dr. Lee. I'm a close colleague and friend of Dr. Leonard. What can I do to help?" It's like what I imagine actors doing before they stride onto a stage. We have to play a role and try to meet our patients' expectations.  

You've known hundreds of doctors; some are good and some would never be very good at this, right? There are people for whom this comes easier than others. I will say this: No one is as good as they could be or should be. All of us need to work at being the kind of physician we want to think of ourselves as being. Trying to create the context in which good people are at their best consistently—that's part of the game.

And then there are people who just don't care. How do you make them care? You need extra nudges reinforcing intrinsic motivations. I think transparency helps, but there are some people who just aren't going to change. And in those cases, organizations have to ask: Should we part company? Toby Cosgrove at the Cleveland Clinic has said that every time he lets someone go, the first thing everyone says is, "What took you so long?"

How does this fit with shared decision making? It seems to be almost a throwback to empathic doctor being in a position of authority and power over suffering patients. I'm not against shared decision making. But I would say I don't think it's going to save health care in terms of quality or cost. It's obviously the right thing to do—share information with patients. But patients are heterogeneous. There are some who really want to go back and forth with you. And there are others who are just ready to say, “What would you do?” In my own practice, there are more people in the "what would you do" category than in the "I want this kind of test" category. But I've got both. Part of being a good clinician is understanding that one size does not fit all.

There's nothing wrong with shared decision making, and there are some good things about it. It's not going to save the world, though. Some folks seem to think it might.

My wife recently used a Minute Clinic. She had a good experience. Maybe there's an appetite for care that is businesslike and that is available when I want it. Do you see a tension between the Minute Clinic and convenience medicine, and what you're describing in the book? I think paying attention to what people want is part of the definition of real empathy. It's not projecting what you want them to want. My wife, Soheyla Gharib, is chief medical officer at Harvard University Health Services. And I was shocked to find out that many students don't care about going to a famous place like Brigham and Women's. They want convenience and access. When they get leukemia, it's a different story.

People want different things at different times. So part of empathy is saying, “This is what matters most to this person.” So it can be empathic to give people convenience.

There's no mention of payers or insurers in your book. Do you see a role for them in this empathic health care?
system that you think we should aspire to? I hadn’t thought of that. But to a payer I would say, “You guys should be providing incentives for transparency on the patient experience.” Make 1% of payment linked to transparency.

The impact of having patients’ comments out online is enormous. It’s transformative. It changes the focus from classifying doctors on how they’ve been in the past to how are you going to be with the next patient you see. So, if I were a payer, I would encourage providers to put comments online in the way that University of Utah has.

Let’s talk about measurement and Press Ganey. In the book, you draw a distinction between patient satisfaction and patient experience. Experience is trying to get more at the totality of things that happen, not just “Did you like the food?” or something like that.

Patients want good outcomes. Death is the most important outcome, of course. Losing a leg, blindness, or stroke—things like that, those are hard clinical outcomes. The assumption is you’ve got to be in the game on the hard clinical outcomes. But it’s very difficult to pull away from the crowd and differentiate yourself on those outcomes. So you better start to differentiate yourself on what Michael Porter calls Tier 2 outcomes, which include the experience of care. That’s where you start getting into the relief of suffering. Patient experience is an outcome that reflects the extent to which we’re meeting patients’ needs.

So patient experience is, in some sense, a matter of relieving patient suffering. Yes. And I use those interchangeably. The other phrase I use is, “Are we meeting patients’ needs?”

It seems that measurement of patient experience still depends largely on patients’ answering questions. What questions do you ask? There are really two different types of questions—process questions and outcomes measures. Process measures are focused on whether or not the doctor or other personnel performed some task, like explaining test results or the purpose of medications. The focus of process measures is on the reliability of providers.

On the other hand, outcome measures are aimed at the question of how is the patient doing. There are clinical outcomes that you don’t need to ask the patient about—like death or amputation. But those measures don’t necessarily differentiate among providers as much as patient-reported outcomes, such as whether or not a patient has sexual function or incontinence after prostate surgery.

Patient experience questions that are really outcome measures tend to get at that critical question of whether or not patients have peace of mind—confidence in the clinician, confidence that clinicians are working well together on the patient’s behalf. One of the major goals—maybe the major goal—of health care is to give patients peace of mind, and I think their likelihood of recommending clinicians or hospitals reflects peace of mind.

In truth, I think that both kinds of measures are important but outcomes-type measures are more important. Certainly, for public reporting it is clear that patients are more interested in outcomes than process. Process measures are important but should be moved internal to organizations trying to improve their own performance.

You mentioned some major problems with measurement. One really fun book that you may know is Thanks for the Feedback by Douglas Stone and Sheila Heen at the Harvard Negotiation Project. They talk about how we get feedback all the time, and we don’t really want feedback. And the first thing people do is they look for reasons to push away that information. And what you really want is to get people into a frame of mind of wanting to pull the information toward them, as opposed to look for every possible reason to push it away.

With all kinds of quality information in health care, there’s the same dynamic of people wanting to push information away. This is the reason we need competition in health care. We need people to want to get better, and therefore pull whatever information they have toward them.

Are you saying the data are not going to be perfect but that isn’t what we should be focusing on? I think you could say, “Look, let’s be realistic. The data will never be perfect, and if what you really want is to find a reason to ignore the feedback, then don’t bother collecting any data.”

I know physicians who worry that the only patients who respond to surveys are people who are angry. That doesn’t seem to be true, given that 80% of the patients give a 5 on a 5-point scale. So, then they said, well, the data all clustered at the top, with people giving positive ratings, and there’s no differentiation. But 20% of people are not giving 5s, so there are plenty of opportunities to improve. The data may not be perfect but are you willing to blow it off and ignore it? Or are you going to try to get better? That’s ultimately a decision for the clinician and the organization. That’s really a core premise of the book, and a requirement to compete successfully in health care.