Introduction to Doctor Hayley Fisher

So excited to introduce Doctor Hayley, Fisher writes. Hayley has been spending the last 16 years becoming an expert in company and organizational culture and strategy and turnarounds.

She's a president of Rose medical Group, and she helped grow the organization, to 560 physicians, which is mind blowing. She is the, CEO of, the medical group Medical Association, or Magma that most people know, which represents a majority of the physician practices, in the United States.

Which is a very, very large endeavor. Together with executive teams, she's worked to grow the minimum membership from 30,000 to 58,000 while focusing on lean and sustainable operations, which is totally what we're going to talk about today.

Very innovative person. She wrote. And she co-wrote one of my favorite books, which is Tribal Leadership. It's actually one of the books that led me to want to have my own practice with a different type of leadership.

And, and I still go back to it to this day. She's named a top 100 healthcare leader in top 25 Women in Healthcare by Modern Healthcare, and a 100 Great Leaders Health Care by Becker's Hospital Review.

So lots of awards. She's been on Forbes magazine and Modern Healthcare, and she's been a speaker and a panelist, a humongous regional and national event.

So really honored to have her here today with us. Well, thanks for coming on. I'm so happy to have you. Really excited to have this talk. How are you doing tonight?

I'm doing well. Chatting. Thank you so much for the invitation. I appreciate it. Yeah. No problem. And and believe it or not, I've been following you for a long time, so what you don't know is that, Tribal leadership was literally the reason I opened my practice in 2017.

So. Yeah. So at that time, so Texas Center for Lifestyle Medicine, I really wanted to redefine what it is because, you know, I was in a previous practice and my slots were ten minutes and I was average and I track everything.

So I average about 6.5 minutes per patient. And it was just not the best model in the world. But it's your typical internal medicine inpatient, outpatient, ICU and hospice, you know.

So, so, but, you know, it's a working model for some. But for me, it wasn't really fulfilling. So, I used, I knew that I need to build a team. So tribal leadership was it was a fantastic book to to kind of lean on.

And so that's why I'm super happy to, to have you on. So thank you very much for that. It's it's pleasure. Yeah. And so I want to kind of jump right into it.

Pandemic Pivot and Practice Resources

So most majority of the people that are watching this, if not all, are physicians. Most are physicians either in private practice or about to go preferences or considering private practice or some who are just considering retiring.

So that's up to that as well. So, you know, I think that, with the pandemic and the pandemic era of practicing medicine. So I'll tell you what we did at Texas, and I've realized some medicine is that in February of 2020, we, decided that after the the initiation of the lockdown that we should switch to telemedicine.

So we went from 5% telemedicine to 86% telemedicine, closed off our set of locations that concentrated into into

one. It was a very difficult business decision.

Yeah. But, but it really came from a podcast, as you heard from MDMA, believe it or not. Yeah. And, you weren't in that one, but really talked about, you know, what to do.

Telemedicine communication. And so, and so I was lucky to really have that information. But right now, you know, we're I mean, I would like to say we're coming out of the pandemic.

It just seems like we're perpetually in one. What can doctors do, like in private practice, to tap into some, like the latest resources to pivot during this, this pandemic era?

It's it's very hard. Absolutely. Well, I think so. This is I'm the CEO then GMA and what we do is we get, we really do have an understanding of what's going on across the country.

And it's very much changing what you describe. It's not unique to a lot of times when we talk about these problems, it may affect people in Texas, more Florida or Northeast or our West coast across the board.

And so the pivot that you did in transferring from really face to face to, Telamon and really pulling the lever on what are the inefficiencies and, and letting it go like this is a tough business decision.

But this is what we need to do. I think it speaks for a couple of things. Number one, being able to resource so that you can kind of understand what's going on across the country and recognize that this is not unique to to you, number two, through either your medical specialties.

So I'm going to assume that there's all medical specialties listening to this podcast or to this interview. There's that you have medical specialties that really focus in on what are the business needs of each one.

But then, when, when the pandemic occurred. And by that I mean between March and mid April, with almost all of the large medical, kind of the more general medical associations got together and said, what are the resources we can create?

And then we allowed everybody to access that. So even if you weren't a member of a Mge or HSM or magma, you were able to access those pandemic resources, and those are still available right now.

As we go into this wave of Delta, I think we're renewing. What do we do? Like how do we refine? And so in a certain way, your pivot pivoting for we're switching, how we communicate and how we do business.

And now we're going to have to iterate on that model I think is really what we're looking at. And so those resources include, recovery checklists that you can get through your medical specialties, societies through MDMA, once again, EMG, etc.

those resources are out there. You just have to seek them out. I think one of the things that we're going to talk about is same, allowing yourself the number one resource you can give yourself is time to to pull your head up and assess what's going on and make a decision on what resources you need to move forward.

And I think that's the, one thing we don't talk about enough is actually create enough space to figure out what your business needs are. You know, it's overwhelming, right?

And so, yeah, you know, I think that when in 2017, when we first started doing telemedicine, you know, it was so we had to pivot because my practice opened, six weeks before Hurricane Harvey hit Houston.

And for Imperial Time, I didn't know if we're going to continue on. So, so so we had to pivot to telemedicine because of Hurricane Harvey at that time.

And so we were able to, to to skew that a little bit. And then, with the pandemic, it's a it's a whole different level.

Yeah. So, you know, at that time I really, held on to the Texas Medical Association TMA and they had all these reasons out there, which is wonderful.

And, and now with the pandemic, you know, it's a whole other level, which I didn't think I was going to see again. Yeah. So trauma that occurred with Hurricane Harvey, right.

So with the pandemic, it's it's it's now everyone's really affected. And now we know it's not going to stop. But this is a new level of normal. And I think that when I talk to my physician friends are like, oh, we're going to wait for this to kind of blow over.

It ain't blown over, you know? And so I what, what we, what I'm seeing in the leadership ranks and what I'm starting to write extensively about, is that the irony of Covid is there is no trend that was occurring in medicine that isn't present during Covid, but it was it's like you got put on steroids.

So everything that's coming, telemedicine, moved to you know, the billing, challenges, the staffing challenges, all these things, burnout, all these things preceded the pandemic.

But now, 18 months later, they're all viciously apparent. And I think one of the things that I'd love to, for people listening to this and watching this to come out of is it's at these times that, you know, I'm a Gen Xer the dare to be great situation.

Well, you really do have to say, I think one of the things about being Gen X, Gen Y, Gen Z is that your frame of reference is okay, we've got a change and that there's a certain amount of flexibility, baby.

Even in baby boomers who served who, how do you change? And you have to have an appetite to do that as well. What you're talking about, first of all, you went through a catastrophic once in a lifetime hurricane and the flooding in Houston.

Right. And you follow that up a once in a 100 year global pandemic. So, I mean, you're a tested leader at this point in time, right? And then, oh, so, gosh, knock knock knock, you know.

Right. And what you what you're looking at is when you come through the second time and you I'm, I know that part of your, summit is around trauma and there's significant trauma, but also through that, there's a sense of pride and accomplishment that you've led your business through to what catastrophic events and you've come out on the other side.

Now, granted, to your point, Covid isn't over.

Burnout, Culture, and Small Wins

But the first wave where we shut down the economy of the United States, that part is over. We're not going to shut down the United States. Now we have to figure out how do we operate in a Covid world, which is a different challenge then how do you make it through everything being shut down?

That's that's a great point. But, you know, I think my my issue with the way that medicine has been taught. So I finished residency, in New York in 2012, the chief resident here in 2013.

And my sister is currently, you know, Columbia University School of Medicine, in her in her fourth year. And so I think that the way that, the, the educational institutions has been, has been responding, has they also have a very large burnout because a lot of things that we're, that we're taught, within institutions and outpatient medicine, inpatient medicine, just like all curriculum just kind of blew up there, like, oh my gosh, what do we do now?

Right, right. So my sister, which we were just talking about this yesterday. Yeah. How right now it's like people are so scattered. Administration is scattered.

Somewhat Ivy League school here. So ministration of scattered. You have doctors that are scattered, nurses are scattered, and everyone's, like, at each other's throats.

Yeah. And, and, you know, one of the things that, once again, going back into tribal leadership is this going from, I think, tomo different stages of, and stages of the cultures of the business.

And within a lot of the, the institutions that are at the stage where people are just like, you know, my life sucks. And transitioning that to a higher stage as you talk about work is just very difficult.

And I think when Covid happened, that happened across the country, the cultures of each of the private practices, really were challenged. And then all the, the deficiencies within each type of culture was on full display.

Yeah. And and now we're kind of like in this rut. So how what do we do? How do we get out of this? Yeah. So, you know, the point that you're making has to do with systems thinking.

So so we had an entire system. I maintain health care isn't a system. It's an industry because it's not closed. And that but let's let's say for the purpose of this conversation, it's a system.

So we applied severe pressure on to the system. We shut off really all financial resources. We took away safety equipment. And then depending on what geographic area where we inundated with unbelievably sick patients and we didn't have the education, we didn't know enough about the virus.

If you were a physician or nurse or working in a hospital to know that you weren't going to bring that back to your family. So there was that element of fear.

It's on top of everything else. The thing about systems and, and I think my entire career kind of speaks to this. You know, we always look at the policy people about push policy down and will make it, you know, Medicare will fix this or my stances control what you can in your world.

If you can control your practice, make shifts in your practice, make shifts in your world that will affect the entire system over time. And so when people are saying, well, I have no control and I can't do this and I can't do that, I often say, let's take a look at it.

The domain of control that you do have, you know, within your practice, right? You don't even need to be a practice owner. I mean, you could be a physician and say, what do you have control over?

And we're going to talk about burnout. I know you are going to talk about burnout. But, you know, when I look at burnout, I think 50% of burnout is is stupid processes.

In other words, we keep as physicians getting more and more pushed on top of this, but we're not removing anything. So we have all these regulations and all these, you know, protocols and policies and everything else.

And no one ever sorted through. This actually is important. And this doesn't matter anymore. And so if you can start with something super basic, I have control of this, you know, 24 by 18 inch space, you know, manage this the best and then slowly extend.

I think there's a sense of, of you need wins. I think as physicians we haven't had wins in a while. That's how you start with the wins and start developing that momentum.

You know, the whole Jim Collins philosophy of getting enough momentum to move the flywheel as physicians, we don't have we don't collaborating enough, really, to get a flywheel going, but we can get our own motors going if we have enough small wins.

Yeah. And in my, in my organization called microwaves, like, you know, microwaves. Right. And you can as something as a, as a simple, you know, thank you text message from a patient through our text platform.

That's a big win. And I try to focus on those things as microwaves, as micro wins. And these micro W's add up to a macro W in which we celebrate once a month.

Because we have meetings once a month, we shut down the whole clinic, have our all stuff in once a month. And so that's really, changed, a lot of the processes that we do.

But, earlier you said 50% of the burnout is, is processes. I feel like for me, that's 95%. But my burnout is that you clarify at least 50%, at least, in. But I think part of it is to recognize that burnout is from an impaired process or impaired system, not a documenting.

And we have other parts of the summit. We actually talk about exactly how to how to do that document systems. And so, so my I think a big challenge in my physician group and especially on these Facebook groups, stuff like that, is that, you know, right before, our talk, as an inspiration, I actually go into these physician Facebook groups, and I just see the last ten posts of what people are talking about.

It's very few of the posts are very positive in general. So a lot of times it's okay, my staff won't bring me water or, or I have, you know, this employees doing that and it is making me look bad.

And I got a one star review because this employee is doing that. And so I think there's so many external blame that the physicians casting on like a single person.

But really it's the system, that's involved. Right. And so, so I want to just kind of go in there and talk to them, you know, on social media like, hey, you know, it might be a system thing, but the problem is, is that every post is basically a pain point of impaired systems.

And the process, whether is talking and leadership, impairments, no processes for patient engagement. And a lot of things are kind of expected. And so I think that, you know, as doctors, we were trained and I was trained that, hey, learn what you can in medical school and residency.

You got to be a good doctor and everything will follow through. I'm not finding that to be true. That's true. I think it's interesting. I think this is very normal in physician culture, and I think physician culture.

And you're familiar with this. If you read Tribal Leadership, it's almost like I try to one up for you with how much my life sucks. Yeah. Yes. And the good news is, physicians is we have endless fodder to fill that wealth that, well, will never get filled.

What? We're not. And we're trained that way. We heard our chief right at the. You know, when we were baby doctors, we heard our chief residents complain like that.

We heard the people above us complain like that. And then really, we got cultured, a cultured into doing that as well. It's a rite of passage. I mean, if I, I finished med school 20 years before you, but, you know, when you went to a morbidity mortality conference, that was the the pinnacle of my life sucks because it was never good.

Trust me. You were presenting. It wasn't good. So oftentimes when I and it's actually why I don't Facebook, I'm active on social media but not Facebook because I think it's it's almost too easy to throw, garbage on the garbage pile.

I think what's much more hard and what's much more leadership behavior is to acknowledge the pain point. And there are. So I'm not saying, oh, no, they're everything's great.

What I'm saying is acknowledge the pain points and then say, great. What have you thought about and how you solve this, or how would you approach it? And when when I took over the the organizations that I took over, they were awesome at complaining.

I mean, fantastic, five star.

Technology, EMRs, and Data Science

And I would say, you know, this is a 95 year old organization. I have no doubt this complaint was present in 1926. So what solutions have been tried over the last 90 years that have worked, haven't worked.

What have you thought about? And I try to move it. I mean, you do have to acknowledge the pain points because it is it's awful. And to move out of the I'm a victim into I'm empowered, which I think is really important as physicians, once you can understand what your leverage is.

But that that that shift from I experienced nothing but pain into how can I turn my pain in the power. And by power I mean ability to do something about it.

Ability to to wield influence in a and I would like to say in a positive way, that is the shift that I think that we're poised on. We can either go all to victims as physicians, or we could move into this is the time that physicians actually take the rightful place in the system of how to take care of patients and start to lead what care looks like in the next generation.

That's kind of the cusp of where we are right now. Yeah. So I think with with coronavirus, it's really challenging that aspect. I think that, you know, as physicians, especially physician leaders in private practice or in practice, we have to recognize that we're leaders, too.

And, but I think we're also reacting to a lot of trauma from, could be residency or medical school, because I feel like and I talk to my friends about this all the time that we went into, we wanted to medical practice.

Well, we wanted to, to to medical school for for a reason. And perhaps somewhere along the way, we realized that the reason that we went to medical school for is not necessarily we're going to get out of it, but we've invested so much time and money and effort into it.

And so a lot for a lot of people, it's like there's little disappointments along the way. And then now you're just like, okay, I'm just gonna follow the leader because, you know, I'm $280,000 in debt.

It's to keep following the leader. And then the leader could be this attending of the ICU, Columbia Presbyterian, whoever it is. Right. And then. And then when something doesn't necessarily match that hierarchical structure, there's this.

There's. We become afraid almost because as physicians, we're taught to pay, practice the standard of care and medicine, do the thing. Do the thing is. Right.

But from a personal development standpoint, you know, our standards really have to change, in each phase of our career. And I feel like a lot of people are kind of stuck in the past not changing into into that, that sort of mindset.

So I felt like that a lot. In my first practice, after after, chief residency and I felt like, yeah, the money's good, everything's great, but it's like the, you know, my mom's an acupuncturist.

Very holistic family in general. So I'm like, I wanted to do this to to have better conversations. Like, I didn't go to medicine to prescribe medicine once, the medicine to have better conversations.

But I feel like my 6.5 minute visits were not better conversations. And my favorite time in practicing medicine in my previous practice was hospice. I loved hospice, I got to talk, I got to interact with the patients family, and it was something that's really fulfilling.

And I'm like, why should I be a house doctor? And then I read Tribal Leaders and I was like, oh, wait a minute. There's this is a new standard, right?

There's actually a mentality that's outside of what I learned that I wanted to pursue. And so, and the whole point of

this entire summit is to get people to understand that there's there's something else there to pursue that's not the standard of care center.

Right, right. Yeah. So how do you how do you achieved how do you foresee that one achieves that? Yeah, I think. Okay. Well that's a that's a massive question.

So I'm stalling while I kind of populate my index cards in my head. Yeah. I think the first step is acknowledging this isn't working. And I think in it was your first what you just said, we're we're accustomed to complaining about things we're not accustomed to, to just basically saying it's not.

And then here's the next step, which you did beautifully. I'm not going to do this anymore. It doesn't make sense, right? When you get to that point that you're frustrated or tired or or, let's be honest, traumatized.

Yeah. The pain is enough that you're willing to make a change. As physicians. There is, I would say, legend that we have in our head that we've gone through all this training, we've spent all this money, we've been up all these nights, we've suffered.

So when we get to be, you know, attendings, it should be good. And easy. And none of us have experienced that, you know? Yeah, yeah. I mean, the thing is, I.

I finished my training 20 years before you did, but I will tell you what you said as well. You know, I figured out and I was already, you know, 30,000 or excuse me, $300,000 in.

It wasn't going to be what I. It's funny, I would have said the exact same thing 20 years ago. I mean, I'll just be honest with you. I'm like, well, well, here's what I've told people.

We were the last generation. I mean, we were the first generation that followed that. It's good generation. And I'll be. And having had multiple, students go through my school, through my clinic when I was practicing and then through my what I realize is we all feel the same way.

But you get to that place where you just it's kind of what I call the Martin Luther moment. Here I stand, and I can do no other. You have to be willing to make a change.

And that I think that's really hard, especially if you're an adult, especially if you've got family, you've got commitments and everything else. You have to be in enough pain to take a risk to do something different.

Either speak up, leave, try something, try anything. But that's where that movement from victim to empowerment occurs is and it and where she been. So we're not going to do that if we're comfortable.

I mean that's really what happens is if you're totally comfortable and things are okay, yeah, might be into me or whatever, but when things really hit that rock bottom, that's typically when we see people interested in making change and can't do it fast enough.

Yes, that's such a great way to put it. And I and I tell people that, there's, there's evolutionary biology says if you too comfortable, your species goes extinct.

There's no longer, where to go. Yeah, well, I don't, I mean, this is very cynical, so forgive me, but I think if I watch a lot of our baby boomer physicians retiring, where they're just like, yeah, I'm not going to do this anymore, and I'm just going to leave as opposed to.

Which leaves us to fix the problem. And and it's that adapt migrate high. It's the evolutionary prerogative. Right. So I have unbelievable faith in physicians to adapt to the changes.

But to your point, Gene, nothing that we've done before has prepared us for the world that we're going into. Which means and here's the upside. We can create whatever we want.

And I think that's that's the way we look at it. We don't have to keep repeating what we've always known. We can be creative. We can put our talents to use.

And you know what I thought was really interesting? What you just said is you enjoyed being a hospice physician because you got time to spend with your patients and talk to them.

And let's be honest, at a, at the moment of need of, of human beings, which if you interview physicians, 80% of people that become physicians say they went into health care because they wanted to help people.

Right. See, the biggest frustration is they don't feel like they're helping people. They feel like they're, you know, inputting data into a computer. Right. Totally.

So now that we've gone through the pandemic and we've done the APM, how's and that's gone now, how do we take that goodwill and that sense within us up?

This is unsustainable and make change. And I think that's very individual driven. Yeah. Recognition of that this is just not working is the hardest thing that I've ever done.

And I and I did it like 6 or 7 times even in the last four years of developing my practice, you know, and talking to and redirecting. And I'm trying to understand what my core values are when our practice core values are as a company.

And then also putting trust in, my, my, my team. Every member of of my team, my practice. Doesn't matter if you're the janitor, the front office, doc office, the medical assistant.

We have a culture there, and we've bonded very tightly. And so, I think that's what a lot of physicians, really, discovered, especially since the pandemic, is, is that the culture glues the team together.

So turnover was massive. Employee turnover was absolutely massive during during the pandemic.

Patient Partnership and Physician Leadership

And so, so on one hand you have this doctor that really wants to say, hey, this isn't working. I want to try new things. So I was like, oh my God, four of my mas just quit, right?

How how does one sort of balance that? Said, this is that this is that whole Maslow's hierarchy. You have to kind of provide your survival, which is. Yeah, you need to see certain number of patients to provide.

And this is a time. So solving the what do I do about my staff. That kind of dives into the whole point of your summit, which is about the use of technology.

And may I add, the appropriate use of technology, which has not historically been the right place for technology in healthcare? Yeah. In in the fantasy, this would be the situation where we start to use technology to do what it has.

The potential to do, which is to allow physicians to deliver care more efficiently, more effectively, and patients to understand, as opposed to acting as a barrier to engaging with patients when those forums leave or their those theoretical AMA's leaving, then I think it's a good time to say with someone you trust within your practice, do we need to replace all forums?

Are there other ways to do this? Yeah. What could we use technology to help us out if that's appropriate? And if not, how are we going to revise our systems to be more efficient, to absorb this and change every single practice administrator I've spoken to is it is undergoing this this challenge with staff.

So this is not unique, you know, used to be know when I, when I owned a practice we would have our we had MH we had a good culture. But if another practice offered $4 more an hour, they would go across the street.

Right now it's for for a lot of EMS. It's about life and death. I'm not going to do this anymore. So you're not replaced. It's not like the cycle of emphasis is coming through.

And so I think it's if you, I think there's a double edge in solving this problem, which is if you're taking a look at your entire practice and saying, how do I solve for this problem in a way different than I just need four more bodies?

You may actually solve for some of the challenges that maybe had 1 or 2 of those four walk out the door the frustration, the boredom, the tediousness of of their job.

Yeah. You know, you're absolutely right. It because I am I she saw this firsthand where so so a big portion of our staff are actually virtual assistants.

They physically are in the office, and from a fixed cost standpoint, significantly cheaper. But, but they always overdeliver, which is great. And so when another practice, decided to they can't afford the rent anymore and we're going to go virtual medicine for most of it, it will go down from, you know, 1200 or 12,000ft² to 3000.

You know, my recommendation is, hey, why don't you try virtual assistants? Because they have six, 6 or 7 staff members leave and including the office manager.

And so the ended up, and this is, six months later, I think he told me that his office manager is now completely virtual. It did a significantly better job.

And then the other half, the staff, was actually replaced by virtual assistants. So they don't need to be in the office. Yeah, but they can be there to help the patients 24 seven because part of it's there on nights and probably on days.

And then and we were just kind of talking about it. I'm like, hey, let's go to Google. Let's look at your last like online reviews. And and he does. He never looks at his online reviews.

I, I look at every online review, and, and we look at it, I was like wow. Like, you know, people are like, really? You know, respecting like like, who is this?

Like, oh, that's my new virtual assistant. We just, we just hired two months ago. So I think that this does exist and that pivoting does exist and significantly reduce fixed costs.

And you guys, you came out of the better than he did going in. So so, you know, I was just saying that just thinking about that, that example. But I think that people, really have to have an understanding that, hey, hey, this happened.

Let's think from a global perspective, a top down approach, you know, how to how to act upon that. Well, and then each reaction is just fill those four spaces, right, right, right.

But that, in the spirit of the world has changed. It's not that you have to do better. You have to do different. And I think the other thing that I'd like to share and and you actually mentioned this in our, in our conversation, one of the things that I tell my organization is I expect you to fail, because as physicians, we don't like to fail, which means we won't risk because we might fail.

So I told my staff, I expect you to fail. I'd like you to fail fast and cheap and only fail one time doing the same thing. These are the kind of the guidelines around failure, but try something, try anything.

Take a risk. You know, calculated risk. But some of these will most of these will fail. Some of them will pay off. And once in a while you'll knock it out of the park.

The strides that we've made during Covid had to do with us taking risks. If we would have continued to do what we did every day in and day out, we wouldn't be here either.

And the story you tell about your friend and about yourself doing, you know, basically coming out of Covid saying, I actually did better than going in for a variety of reasons.

I won't say that's a common story, but I've heard that enough to know that there's there is room for that type of development. Yeah. And that's so powerful.

So earlier you talked about, technology and you said some are good and some are bad. Yeah. Can you kind of expand out a little bit what you mean by that?

Yeah. So I think the so let's take wearables out of this conversation. Let's just talk about kind of the business software. When technology entered into the medical practice, the entire source of of that was for billing and compliance issues.

It wasn't engineered to be end user friendly. It wasn't engineered to enhance the patient encounter. It was engineered to capture charges to be efficient and to provide compliance with billing.

That was it. And to be honest with you, from a standpoint of that, was the goal of that software, the initial electronic health records and things like that.

The the dream of electronic health records was that every patient would have a portable medical, history walking with them. The reality is it became a tool to communicate with health insurers.

Now we're in kind of version I would call it 4.0 where we're starting to see end user meaning both the physician or provider and the patient having some, some quality with it.

And I think as we add in AI interfaces that help bridge the gap with the tedious stuff, you don't need, a physician who's been in medical school and residency for 14 years to go check, check, check.

That's what an AI interfaces for. Now we're seeing where technology can actually come in in a meaningful way and actually enhance the physician patient relationship, as opposed to being a barrier to the physician patient relationship.

So, you know, when you, when you, this technology first came out and you talk about end user. So the when what was what the EMR was supposed to be, which I thought because, you know, so my first no, you know, my, my first year of medical school, I was in it was in the hospitals, all paper.

And it was in the, the were using medical students like myself to transition into electronic, which was meditech at the time. Yeah. Meditech. Exactly.

And, and I just thought, wow, this is great. I don't have to read illegible handwriting about my third year, of medical school. I'm like, I am so sick of the system because now there's so much more work to be done.

Like what happened here? And now, you know, with our current EMR, with, you know, like, clinical practices, you know, a lot of things are just kind of big question marks.

And I feel like a lot of customization needs to be done. So the technology is there. But is it utilized fully by doctors to improve their lives? No, it's it's it's really not.

No. I been going to the clinical conference for the last three years and trying to improve everything. I learn more and more things. And now now it's going to be better because, you know, our user experience is much better because we're able to customize things.

But, it's not and it's, it's, it's some of the things that are useful for some of the things. And reporting to our echo and all those things are not it.

Just click, click, click, click, click right. And so that's become that's become kind of kind of kind of crazy. But in, in March, March of 2020, we started partnering with with Withings.

And then we, we started integrating the Withings with our EMR platform. And we did a Covid screening. So they were using O2, SAP machines and blood pressure and everything like that, basically remote patient monitoring.

We were able to identify people going south pretty quickly and then the test on to that. And so so that was a that was my first like really good experience with, with the technology component to it for you're right.

Like now there's AI and there's algorithms working. Not just that one, you know vital statistics but what what is what is the slope. How much what does the velocity of increase of body temperature and how does that correlate.

So, I think that a lot of physicians are really scared about AI, like going to take over a job and stuff like that. Now it's really try to enhance us to, to, to scale the things that we want to do.

But but but I have a fear though, and this and tell me if I'm wrong, but my fear is that whenever you have this technology and it's being monitored, you know, eventually everything's going to be hacked.

I feel like. Right. Yeah. And so you have this data and the insurance has has the data, they know who to risk stratify. And so and so now I feel like the doctors should have the data and we as a group should know what to do with it.

Right. And so how do you think we can leverage the new technology, in using this data to help us, the physicians, the actual end users, between the patients, how to help us practice medicine better.

Do you know any ideas about that? I do, I think it goes back to your point about medical education. So in medical education, lots of facts, lots of figures, anatomy, chemistry, neuroanatomy, all that in there now I think needs to be data science.

And the reason why is the infirmary used to be the physician was eye in the eye. Beneficent Lee was the SPO bestowed knowledge upon you? Right. I give you my opinion. It's.

You know, this is before Doctor Google came into town. Now we curate information. Right. So I don't know, you have a conversation with your patient and they're like, I saw this.

I read that there was an ad for this. You know, we're going to start seeing advertisements for Pfizer Covid vaccine on TV, starting at the end of this week.

So I do think that there's something around putting in their data science in the sense that I think one of our jobs is being able to not necessarily collate that information, but how to interpret it and find meaningful trends out of it.

And I view this very much like the first integration of electronic health record. And and I also used a clinic works. This was ten years ago, and I remember going to my first conference and we sat down and they were like, you can do this and that.

And here's what I thought. I'm too busy to do all this stuff, right? So I can click, click, click and do the patient know and have enough so that I can bill and I'm done.

And I don't think that's dramatically changed in ten years. But I think starting with medical education and understanding that you're we're still being trained like we're the receptacle of all knowledge.

And that isn't true. Now we need to be trained that we trade information and that we use data to inform how we curate that information. That's, the big task now.

Yes, yes, it only takes medical schools 100 years to make changes like that. So I'm cautiously optimistic that they'll

do it before I die, so. Well, you know, there's programs now actually for physicians.

And actually there's some MBA programs and physician SEO programs that are trained specifically this, like how to analyze the data from a business perspective.

How do you how do you help more patients, not just help more patients, but overdeliver on value? Yeah. Because, you know, physicians, as physicians, we don't have training on, on, on marketing.

And I don't think doctors see patients as clients. And I actually think we actually should because we really want to deliver that, that value. And doctors don't believe a lot of doctors don't believe that we're actually in the service industry, but we are 100% in the service.

Absolutely. And so, you'll go ahead. Sorry. Yeah. It's funny you say that because, when I, I ran a very big practice, I owned a very big practice. And I would say client and, and my colleagues would cringe and I would say, look, in a certain way, when you say client, you have a higher onus to deliver service than if you say patient.

So that's the burden on us. It's not devaluing the patient. It's actually putting the onus on us that we we must deliver a better experience. Right. And that's true with our teammates.

You know, you run a group of people, they're your clients, you know, the culture you're creating. They're your clients as well. So it's it used to be that was anathema.

Now in this generation of the the customers. Right. And frankly, people are paying more and more for their health care. So they really are clients in a true business sense.

And they have decision rights. What they are going to do that becomes fundamental to engaging your patient in a meaningful way. Yeah. No, I absolutely agree with you.

So, maybe it's not surprising. So during the pandemic, and I saw a pattern that was pretty concerning. And that pattern is the media is using military terms for physicians.

Frontline. Right. I mean, that that's really work. Yeah, yeah. We're in a battle. Yeah, exactly. And, I have an issue with this is because, you know, as physicians, we shouldn't be that level of hero worship, more of guides for for our patients and whatever, that labels put there, it's romanticized.

And so, so what happened was, you know, in New York, they recruited medical students to help out with the Covid patients. They're not trained in infectious disease or isolation.

Not even close. Right, right. And and so and so these these people are, you know, there was I think it's new York Times that all these medical students are put in the, the front line.

And I'm like, I have a big issue with that. And we really have to change the language. So I think that and just tell me what you think about this. This is a little bit bold.

Yeah. I think the role of the doctors should really change at this point in this country. So I'll give you example. So, if a patient walks into, a doctor's office, and usually the greeting is, oh, hi, Mr.

Smith, what can I do for you? Right. So the minute that the doctor says, what can I do for you now, that's a that's that's that's that's a question delivering from a hero to someone that needs to be saved.

So the way that I train my staff and myself, to discuss with the patient, throws a patient off for a little bit. So I sit down and, and I was like. And, and what I, what I, what we usually do is a master chart review usually by the same patients is, are they seen 5 or 6 different doctors because we want our chart review.

And, and when we sit down we're like, what are the goals of your health for this year? And what do you think our

role is. Yeah. And they kind of like sit back and we're like, oh, let me think about that for a second.

But that opens a completely new, you know, guidance relationship where the patient's, you know, actually the hero and I actually learned that from my health coaches and motivational interviewing because we have two health coach practice.

And then I think when I started doing that and this probably the beginning of 2019 when I started doing that, it's like, the, the demeanor, like someone's body language can be very irritated.

Demeanor just like starts relaxing. And so when I made it like, like this is my sort of policy, you know, let's, let's start asking these questions. What are the goals of your health and where do you see us fitting in?

Yeah, you take out all assumptions of a relationship. And so and so once. And then when the patient, you know, responds back to us what, their goals are and how do we fit in, we can very easily tell them, hey, this is what we can do, but we're not equipped to do this for someone else is.

So I would love to to, I would love to offer you to do this, but someone else can do it better. So we're not doing this, but let's focus on this first.

Yeah. And I think that created a very sort of beautiful relationship that's not very like militaristic. You know, I bestow upon you. Right. And, and it creates a much, much better conversation.

Like, would you agree with that? I, I think you so. Those type of interview techniques where you're inviting the patient, the client, if you will, to be your partner and you're not approaching it from a paternalistic standpoint.

Yeah, is absolutely the direction that we need to go. And I'm going to basically put it out, not from, it's the right thing to do or ethical perspective, but because your partnership with your physician anymore is a huge financial consideration.

The physician recommends what you choose to do, your partnership with your physician, your likelihood to take their advice or not take their advice has a massive impact in the socio socioeconomic quality of that individual's life.

So I do think that there needs to be a radical change. And the traditional approach, what I am finding is what works for you may not work for someone else, so I think everyone kind of has to find their way.

But, I think the way you describe it is very elegant and the what's interesting, what I'm the story I'm thinking about in my head is this week, my father, who's towards the end of his life, he's he's a young guy, actually, but towards the end of his life, he has interstitial lung disease.

He has multiple sclerosis. He, ran out of oxygen, got taken to the hospital, really wasn't able to communicate what his needs were, got evaluated long story short, got admitted to ICU, and, the ICU doc didn't speak to him and was doing all this stuff.

And I sat down with my dad and I said, and he has dementia from from his, neurologic disease, early dementia. And I said, dad, what do you want to get out of this hospitalization?

Because, you know, on know you're not going to he's not going to ever be normal again. So what do you what he said I and it was pretty simple. I went breakfast because he was hungry.

No one had fed him. I wanted to be able to at least go to the bathroom by myself. And and if we can do those two things, I'm good, then I can go home.

I mean, that was really what he wanted. And it was it really struck me, it goes to your point when you're sitting down after an hour reviewing complex charts, sometimes your client, their wishes are pretty simple, and we have an entire algorithm running, here's how.

Here's the if you will change the battle plan for the war we're going to wage on this chronic disease. Right? Yeah. And really, what they want is breakfast.

And to be able to go to the bathroom by themselves. And so that's where I think it's it's good to check in. I think the way that you did is beautiful.

But I think as we mature as physicians into this new world, kind of bring this conversation full circle, everyone's going to have to figure out how to have that conversation in a way that's comfortable for that, right?

Oh, absolutely. So yeah, thank you for for that validation because I think, we kind of switch our language really increased all of our, but not necessarily relationship with the patients, but actually relationship with ourselves.

I think, at the end of the day, that type of of speaking really, let's let us out of this cycle, we're so tied to the patient outcome. Yeah. And, and honestly, I'm when we review charts, we go full in.

But you're right, majority of the time they're asking for, like, 1 or 2 things, and they're like, good. And they feel good. And, but the fact that we're actually asking them is it's it's really sad that they don't expect it.

They just kind of pause and sit back down like, oh, no one's really ask this before. Let me think about that. But I would ask you, I mean, you've made tremendous impact on your patients clients, but for you as a physician, to be able to sit with your patient and to ask those questions, I get the sense that you feel this sense of connectivity.

Yes. And validation that you're doing what you went to med school to do what you're with, wanted to do that you may not have had in another arena. If you're like Mr.

Jones, why are you here today? You know, and, he like, I can't handle five complaints. You're going to need to reschedule that kind of thing as opposed to, you know, so I think the the benefit goes both ways.

What what physicians when you study what physicians want, it's validation, not boys, but that sense of internal validation of I'm making a mean and making connection.

And I do think that's why a lot of people are burnt out and lost, because they've lost that sense of connection. Yeah. Beautifully put. Well, you know, and that is bringing full circle.

I think the lesson here is, we really have to kind of express what we want as physicians, to our staff or patients, to each other and not have that sort of hostile personality.

I think, that we kind of sometimes see in this Facebook groups and stuff like that, and, it's all about connectivity and love. And, and that's truly going to kind of decrease, our burnout.

So I want to really thank you for the talk. It's been absolutely wonderful. We're way over time, but I do not want to stop you at all. So thank you so much for being on.

And, I'm going to go ahead. And for those of you watching in the in the description of this video, there's going number of links for, MDMA and go ahead and check that out.

And, by the way, is there a conference in 2022 upcoming. Yes. Well, okay. At the end of October, we're having our medical practice leadership conference.

It's going to be in San Diego. We're doing both an in-person event, vaccines required, and then we're also doing a digital event a few weeks later. Okay. Great. Wonderful.

So I just want to make sure that's not canceled or anything. We'll put the links to that in the description as well. And what about in 2022 is there's been more things coming up.

Yeah. We usually have 3 to 5, conferences a year. That means shift a little for 2022, but we're still planning on having at least three. Great. Awesome.

So you go ahead and look at the links and then, we go ahead and just check it out. But thank you for being on. I'm just going to close it out here by saying that we really kind of inspired me to and from the very beginning, tribal leadership.

But now after this talk, I feel it really high sense of validation. What we're doing. And thank you for speaking to all the audience, the physician audience.

So doing a wonderful job. So thank you very much. Thank you very much. For.