Settle in for the Long Haul

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What follows is my Top 10 List of lessons that I have learned on my personal journey from researcher to quality improvement manager to delivery system leader. They are listed in roughly the order in which I became aware of them. For virtually all, the educational process is still at work.

**Lesson One: You Don't Need a Game Plan**

There have been times when I thought I had a game plan for my career. There have been more times when I was worried that I didn't. But the plans that I made have not been durable for more than a few years at a time, and the worries have proved unfounded. I’m old enough now to understand that a good career has several phases, and no one can predict what opportunities will arise down the road. So I have always just tried to do a good job at the work at hand, and chosen work that seemed worth doing. The work that has seemed most worthwhile has been taking care of patients and improving patient care itself. And I have had some excellent mentors along the way who combined high standards with openness to new ideas.
Like most people in academic medicine of my era, I began by identifying with the professors and trying to become one of them. In the 1980s, that meant publishing a lot of original research, securing grant funding for yourself and then your trainees and then showing that you could nurture young talent in the same mold. I set off on just that path for the first decade of my career, but the professors I was imitating were people like Lee Goldman and Harold Sox, innovators who were creating general internal medicine and clinical epidemiology. Their broad perspectives were more attractive to me than the more narrow focus of laboratory research.

I worked with Lee Goldman from 1980 to 1990, performing research on cardiovascular syndromes, emphasizing risk stratification and cost-effectiveness. Although there was no particular plan, this work naturally led me to become interested in critical pathways and quality improvement. Risk stratification allows you to identify more efficient strategies for low-risk patients, and critical pathways can make enactment of those strategies more reliable. The only problem was that our own colleagues often didn’t follow the guidelines that we were recommending.

That is how I edged into management. H. Richard Nesson, MD, then the president of the Brigham and Women’s Hospital, said to me, “You are always writing editorials saying what people should do. How would you like to spend some time trying to get them to do it?” With Troyen Brennan, I started doing part-time “quality research” for the hospital, and we soon were running the Quality Department. When Partners HealthCare System was formed in 1994, we were both asked to take full-time management roles – mine as chief medical officer of the network, which was implementing contracts under capitation.

Today, I oversee clinical performance (safety, efficiency and reliability) at a system level for Partners and get to play a role in health policy at regional and national levels. I would have loved to have that goal at the outset of my career, but the path I took to reach this place was anything but linear.

**Lesson Two: You Don’t Need Power**

Troy and I became influential at Brigham rather quickly, even though we didn’t have any power according to the organization chart. In fact, climbing the chart was not our goal – we were still very much in the academic mode, hoping to write papers and become professors. But certain behaviors that came naturally to us led to a rapid accumulation of responsibility, along with resources. I cite these behaviors not to be boastful but because they might be useful to younger colleagues seeking to follow a similar path.

First, we behaved like we were interested. We went to meetings, we paid attention and we volunteered to do things such as draft a memo summarizing options and their pros and cons. Meetings would reach that awkward moment when many attendees would be wondering who is going to do something so we can get out of here? And we would
volunteer to write that memo, and then do it overnight. Our colleagues were grateful (to get out of the meeting), impressed with the turnaround and often ready to go along with our summary of the situation. We learned that whoever does the first draft has tremendous influence even if they don’t have any power.

Today, I am frequently asked by trainees what kind of job they should seek if they want a career in management; they are worried that no one is ready to offer them the 80% protected time they seek. I tell them to take a job doing as much clinical work as needed to support their salaries, and go to meetings and volunteer the way Troy and I did. Before long, management will be seeking to “buy” their time so their influence can evolve into leadership.

**Lesson Three: Do Primary Care**

Many of these prospective physician-managers who seek my advice have plans to become hospitalists or other types of specialists. If they are open to the option at all, I encourage them to go into primary care. I myself am a cardiologist, but I have been practicing primary care almost exclusively for the past 20 years. As is well known, primary care is hard and relatively undercompensated, and other fields seem more glamorous. Those are just the reasons to go into primary care if you aspire to be a leader in quality improvement.

Primary care is like being a foot soldier in the army. You are indispensable, and everyone knows it. You work with everyone, and you develop the multilayered relationships with colleagues that make it more difficult for them down the road to refuse you when you ask them to consider actions that require them to change their behavior or make less money.

As a primary care physician, I adopted a policy of never saying no to colleagues when they requested clinical help, such as a request to add a patient to my panel or perform a consultation at the end of the day or on a weekend. As I say yes, and as they thank me, I often say, “My rule is that I never say no to a colleague.” My hope is that they will get the message and reciprocate on clinical and non-clinical issues down the line. That hope is not always fulfilled; but, surprisingly often, it is.

**Lesson Four: Communication Skills Matter**

Like a lot of physicians and physician-managers, I don’t use much of the organic chemistry I learned in college. The skill sets acquired during my undergraduate days that have proven most valuable were those I learned working at *The Harvard Crimson* and other magazines and newspapers. This journalism experience taught me to write clearly and quickly, enabling me to generate those memos overnight, for example.

No one is born a good writer or a good speaker. You have to work at it. You have to do first drafts, get feedback and revise them. You have to practice your talks out loud, ideally with an honest and critical colleague. That means getting started on talks and
important writing pieces well ahead of time – the work product from all-nighters is never as good as it could be.

Being a good communicator takes other types of discipline, too. I still review Strunk and White’s *The Elements of Style* every few years to remind me to write with as few words as possible. I tell younger trainees that they should think of every communication, even an e-mail, as a job interview. People are always evaluating you, even when you are writing a clinical note or casual e-mail. No one will think less of you if you write with correct grammar and spelling, but some might if you do not.

**Lesson Five: Branding Matters**

Early in my career, Lee Goldman urged me to be disciplined about the topics I chose for my research. He said, “You have to have a clear idea of what you want people to think of when your name comes up.” Lee didn’t use the term “branding,” but that is what he was teaching me. And just as is true for companies, clear thinking about one’s brand can help an individual stay focused and be more effective.

In the first phase of my career, I tried to build a brand of “rigorous research on common cardiovascular topics (e.g., chest pain) for which risk stratification might enable more efficient care.” Not exactly Madison Avenue material, but it served its purpose.

By the mid-1990s, when I was evolving into a real manager focusing on quality and efficiency, I was asked by leaders at the National Heart, Lung and Blood Institute to co-chair a meeting at which new cholesterol guidelines were introduced to the public. I was flattered but confused since I had never published research related to lipids. Their answer was this: “We thought you represented responsible managed care.” They went on to say that they could not think of anyone else who did, but that response made me think – I like that brand.

In truth, I have been trying to build that brand ever since. I want to be seen as someone who is not afraid to talk about money, who is willing to struggle with the financial challenges of making healthcare affordable, but is also not embarrassed to take on quality issues at the same time. Today, the linkage of cost and quality is much more widely accepted than a decade ago. But knowing back then how I wanted to be seen by my colleagues has made doing the work necessary to get there relatively straightforward.

**Lesson Six: Decide Whether You Are Going to Be a Critic or a Playwright**

You must choose whether you want to be a critic or a playwright. This choice seems like a trap. My suggestion that you have to be one or the other is a bit artificial, of course; but, at the end of the day, playwrights have to put words on paper and be ready to live with the criticisms of the critics. In life in general and healthcare in particular, there are no perfect solutions that make everyone happy. The “playwrights” have to propose
strategies that as many stakeholders as possible can live with. The critics have to point out all the problems with them.

I want to emphasize that I am not using “critic” pejoratively. You need both critics and playwrights, and you can’t have great playwrights without great critics to keep them honest. I think the “playwrights” (often leaders who are also managers in healthcare) should accept that critics are playing an important role and not take their criticisms personally. In the same vein, critics should understand that choices among unattractive options have to be made, and at some point criticism can blur into sabotage.

I encourage younger colleagues to consider carefully whether they really want to be a playwright. Is conflict with colleagues unbearable to them? Are they willing to work on unpleasant topics such as efficiency? Can they take criticism that they are not being visionary enough? Jim Mongan has often said to me, “You are not being a leader if you are not in front of your troops, but you are not being a leader if you are too far in front.” The implication is that if no one is following you, you are not really leading.

My bottom line is that we need both. We need critics who are willing to be too far in front and who have the courage to point out that we are tolerating what is actually intolerable, or trying to sustain the unsustainable. And we need playwrights who are willing to take on responsibility for making everything work.

There have been times in my career when I have written idealistic pieces that my academic colleagues called inspiring but that caused me to be viewed as sanctimonious when I went back to my “day job.” Both adjectives were deserved. When I recognize the choice today, I opt for being the quiet playwright rather than the visionary critic. But I am glad (and a little jealous) when others choose differently.

**Lesson Seven: There Really Is Something to These Social Sciences**

One common syndrome among physicians who land in leadership roles is thinking that they can just follow their instincts. In fact, physicians’ instincts are frequently all wrong and support a conflict-averse, individualistic medical culture that has a hard time providing the coordinated and integrated care our patients need. I did not take any of the courses in college that might have introduced me to areas of expertise that I need today in my role as a physician-leader-manager. Here are a few of them.

**Behavioral Economics**

Behavioral economics describes irrational human behavior, such as why people who are mildly pleased with a $100 bonus become very upset at a $100 loss. Or why offering a $200 bonus does not produce twice as much activity as a $100 bonus. These examples come from Prospect Theory, which won the Nobel Prize for Economics in 2002. The major lesson of Prospect Theory is that you get your greatest “return on investment”
from your incentive programs if they are packaged as multiple small potential losses. Thus, in our contracts at Partners HealthCare, we tell our physicians and hospitals that their pay is X number of dollars. But we withhold some portion of that payment, and they are at risk of losing their money if they don’t hit specific efficiency, quality and safety targets. Prospect Theory teaches that the threat of a loss of a withhold leads to more action than the offer of a bonus of the same amount upon a lower base payment.

This makes no sense, of course, because the difference in these two approaches is only in how the arrangement is described. But people are not rational. And Prospect Theory and much of other areas of behavioral economics do not make irrational human behavior rational, but they make it predictable. Thus, some attention to behavioral economics can help make incentive systems more effective.

**Game Theory and Development of Cooperation**

All too often, people do not cooperate even when doing so would make them better off. This problem is not unique to healthcare, and social scientists have been studying it since the Cold War era, when Game Theory was developed by scientists at RAND and elsewhere. Game Theory helps describe the patterns by which we all too often descend into organizational dysfunction, and why we get stuck there. When I learned about Prisoner’s Dilemma and Nash Equilibriums, I realized – oh, this is why I can’t get anything done.

But there is also good and very helpful work on how to foster collaboration among distrusting parties. The work of Robert Axelrod, who wrote *The Evolution of Cooperation* (1984) and other books on this topic, is especially useful. You learn simple strategies like “tit for tat” – don’t commit a wrong against the other party, but you must retaliate if they commit a wrong against you. That retaliation may cause short-term tensions but is necessary for a long-term stable relationship. Axelrod’s work also taught me to schedule frequent regular meetings among adversaries. They have to learn that they have a shared investment in their future together – in short, that they are stuck with each other.

**Negotiation and Conflict Resolution**

Like most physicians, I do not like conflict. But somewhere along the line I learned that conflict resolution is exhilarating. To my surprise, I find that I really enjoy negotiations, even if the tension makes my stomach churn. I have learned some basic steps from books such as *Getting to Yes* by Roger Fisher and William Ury (1981), so I at least feel like know what I am doing amidst tension. I often compare conflict resolution to running a code for a patient who has had a cardiac arrest. The outcome is not always good, but having a sequence of steps in my mind gives me comfort as I lead the effort.

For example, in internal and external negotiations, I never expect to get resolution at the first meeting or discussion. I go into the room to listen, and the first question I ask
is, “What do you want?” The next meeting’s question is often, “What do you need?” And the third meeting’s question is, “What can you live with?” After all, negotiation and conflict resolution are not really about winning and losing; they are about coming up with an arrangement that all parties find bearable.

Lesson Eight: Confront the Right Side of the Curve
Everyone knows the famous bell-shaped curve from the research on dissemination of innovation. And everyone finds the work on the left side of that curve exhilarating – the innovation, which is created by the 2% of people who are free thinkers, reading and learning from other industries; the early adoption by the 14% of people who may not be reading or learning from other industries but are open minded enough to be watching the innovators carefully; and then the first big bolus of the early majority, who are willing to change their behavior when evidence accumulates that a new way is better.

What is not so exhilarating is dealing with the right side of that curve – the late majority, who are not inclined to change even if the evidence suggests they should. These people usually need peer pressure, the fear of standing out in a bad way if they do not conform to the growing norm. And then there are the traditionalists, the holdouts who will not buckle even to peer pressure. Often they will only change when confronted with authority, such as the loss of credentials at their hospital or exclusion from contracts.

In the conflict-averse world of medicine, particularly in the ecosystem of delicate egos that exists at most academic medical centers, the right side of the curve is often addressed inconsistently and ineffectively. In my work at Partners, I have learned that doing my job means being willing to take on the right side of the curve. You might not have to do it right away, but you eventually have to do it.

For example, when we began pushing electronic medical record adoption in our network in 2003, only 9% of community primary care physicians and 2% of community specialists were using them. We began with carrots – that is, incentive dollars from our contracts. But once we felt that we were past “the tipping point,” when more than half of the primary care physicians were using electronic records, we went to “sticks” – and told physicians that they would be out of our network by a certain date if they did not adopt. Using this approach, we were able to transform our network so that 100% of primary care physicians and specialists now use the electronic record. To reach that 100% level, we had to kick out about 160 physicians (from a total of about 6,000). They were angry, and we were sorry to see them go. But we had to confront the challenge of the right side of the curve.

Lesson Nine: Confront the Loneliness of Modern Medicine
I don’t feel that old, but the culture of medicine has changed enormously during my career, and I can only hope I am going to live through a second change of comparable
magnitude. The first change is a sad one in a way—medicine is a lonelier type of work now than when I entered it. To understand this change, you have to understand the impact of the explosion of knowledge in recent years upon medicine.

Amazing though it might seem, when I was in medical school, I was taught never to open a book in front of a patient. If you need to look something up, I was told, leave the room because you want your patients to believe you have everything upstairs in your head. It sounds ridiculous today, and it was probably ridiculous back then; but we really tried to read the entire textbook of internal medicine and to know everything. Today, I use Google right in front of patients. Somewhere along the line, I started calling my wife, who is a real expert in women’s health, for advice while my patients are in the room. Recently, I actually had a patient ask me if I wouldn’t mind calling my wife to see what she thought. This is the new definition of family medicine. In the old days, one doctor took care of the whole family. Today, you need a family of physicians to give one patient state-of-the-art care.

More knowledge means more physicians need to be involved in the care of virtually all patients. But not everyone has someone like my wife to call. Many physicians go through their day incredibly isolated, even if their need to work together has never been greater. Ambulatory physicians do not go to the hospital. No one reviews films with radiologists. Everyone refers patients to colleagues whom they do not recognize when they pass in the hall. It is a lonelier life in medicine.

I miss the social life of the old days, but I worry more about the lack of a sense of “groupness.” In the 1980s, when a study would get published in *The New England Journal of Medicine*, we would talk about it in the lunchroom or in the hallways, and I would get an idea of what my colleagues thought it meant we should do. We were not always right, but there was more of a sense of “how we do things.” And I really do believe the teachings of *The Wisdom of Crowds* (Surowiecki 2004), which points out that groups of people tend to be smarter than the smartest individual. In those big gray areas of medicine where there is no right or wrong, there is a bell-shaped curve of what rational people (your colleagues) are doing. Wouldn’t you want to know and be a bit nervous if you were at one end of the curve or the other?

To use an example provided by Jim Locke, MD, of Boston’s Children’s Hospital, pediatric interventional cardiologists frequently dilate stenotic aortic valves with balloons. The bigger the balloon, the greater the clinical benefit—but the greater the risk for complications too. Therefore, there is no ideal complication rate. If your complication rate is zero, it means you are not using big enough balloons and other clinicians are delivering more benefit to their patients. If your complication rate is at the high end of the curve, it means you are being a bit reckless compared with your colleagues. The ideal complication rate is to be right in the middle.
In a sense, my colleagues and I have been extending the work of Wennberg and Fisher and others from Dartmouth and exploring variation at the individual provider level. For example, we have found several-fold variation among physicians practicing right next to each other in rates of head computed tomography scans per 1,000 emergency department visits; in the frequency with which radiologists recommend additional testing at the end of their reports; and in the use of nuclear cardiology. When we go deeper, by reviewing charts and analyzing other data, we find that physicians who use more resources are often younger, less experienced and less willing to live with uncertainty. We also find that they have no idea that they are practicing differently from their colleagues.

We think that an important tactic for delivery systems such as Partners is to create peer pressure. We can only do so much with financial incentives — after all, there are only so many targets you can get people to concentrate on. However, you can feed data back to physicians on a wide range of topics, and they will give a lot of energy to the ones where they appear to be below average. So we work to provide reports that give unblinded, ranked data to our doctors on quality, efficiency and patient experience.

But for these reports to have impact and lead to improvement, we need physicians to feel that they are part of a group, that the group has a norm and that that norm has relevance for them. In short, we have to help them understand that they are not alone. And that means learning some soft skills about organizational culture — yet another topic I did not learn about in medical school.

**Lesson 10: There Will Be No Breakthroughs**

I am an optimist, and I think healthcare is getting better all the time and will be much better a decade from now. But after years of intense enthusiasm for one innovation or another (e.g., critical pathways or electronic medical records), I now tell my colleagues not to expect a breakthrough. No major innovation will solve our problems and make everything fine. Instead, what we should expect is door-to-door fighting for the rest of our careers. Every unit of organization in healthcare will need to work constantly against its organizational dysfunction, and try to make its care safer, more efficient and more reliable.

My message is not a pessimistic one. I’m actually saying that the right attitude is what some call the “Toyota culture” — the relentless pursuit of something better than we have now. The journey will never be over. I say that because I don’t want to be a fraud and imply that if we just push for the adoption of electronic medical records, our problems will be solved. I don’t want to hope no one remembers promises I implied about electronic medical records when I push for widespread use of patient portals, or pay for performance or bundled payments.

We will never be done. We have to settle in for the long haul. I actually feel that there is a nobility to that, just as, for physicians, there is a nobility to going in to work every
day and seeing patients whom you can help. And then starting anew the next day. I am beginning to look at the work of improvement as a manager in just the same way.

I have been acquiring insights (e.g., how to use incentives) and skills (e.g., negotiation) along the way without any structured plan — often on a “just-in-time” basis when the skills were needed. I have watched my colleagues struggle with the same challenges that confront me, and tried to learn what makes some so effective, and others less so. I have learned a lot from managers and leaders in non-healthcare fields and from writings in other disciplines. My fond hope is that, for the next generation of physician leaders, the essays in this book will make that learning process faster and smoother.

**References**

**Bibliography**
Listed below are five favorite non-healthcare books that have been most valuable as I take on my work. They are all fun to read, too.


**Thomas H. Lee Jr.** was professionally prepared as an internist. He has been a health system leader, writer and editor. We invited him to present because he has led change in large complex systems and has reflected on his work, making his insights accessible to others.