Fixing Healthcare Episode 8 Transcript:

Interview with Chip Heath

Jeremy Corr: Hello and welcome to Season Two of Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. I am one of your hosts Jeremy Corr. I am the host of the popular New Books in Medicine podcast and I have with me, my cohost, Dr. Robert Pearl. For 18 years Robert was the CEO the Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author the bestselling book "Mistreated: Why We Think We're Getting Good Healthcare and Why We're Usually Wrong."

Robert Pearl: Hello everyone, and welcome to Season Two of our monthly podcast, aimed at addressing the failures of the American healthcare system and finding solutions to make it once again the best in the world. In season one our guests were chosen for their expertise within the current health care system, their bold plans drew thousands of listeners and sparked a national debate. The best of the boldest of their ideas were part of the first-ever Fixing Healthcare Survey, which you can visit my website RobertPearlMD.com. Please go there to check out the survey results and add your own comments. We'll be sharing the best listener ideas on air throughout the second season. This year we are welcoming guests who come to us from outside of the medical mainstream. We're looking for new, unconventional ideas and, most importantly, practical, proven strategies for making change happen.

Jeremy Corr: Our guest today is Chip Heath. Chip is a professor at the Stanford Graduate School of Business, teaching courses on business strategy and organizational change. He, along with his brother, Dan, is the author of four New York Times bestselling books, including "Switch: How to Change Things When Change is Hard," and most recently, "The Power of Moments: Why Certain Experiences Have Extraordinary Impact." Chip brings his expertise and insights from outside of the world of healthcare and offers insights into the types of approaches medical leaders will need to embrace if they want to translate the opportunities that exist into reality. As he will explain, change won't be easy, but it can be accomplished.

Robert Pearl: Chip, I've read all four of your books and when I was CEO in Kaiser Permanente applied the concepts to solving challenging healthcare problems. I can assure listeners that similar to many prescriptions in medical practice, yours and not always pain free, but they are effective. To introduce listeners the different ideas and their applications, I thought what we might do today is the following. First, I'll ask you to present, one at a time, some of the approaches you have found most effective in the hundreds of organizations with whom you've consulted. After each, I will translate the concept into a relevant healthcare context and opportunity. Then I will ask you to expand on your approach and offer other ideas that you'd recommend people consider in addressing that

particular medical challenge. I recognize the complexity of the healthcare system, that there are multiple layers of accountability. In season one, our guests talked about five of them. There's federal government, including Medicare, health plans, there's physician hospital leaders, there's the physicians and nurses, themselves. And of course, most importantly, the patient.

Robert Pearl: Your thoughts as we go along, each of these will be helpful, even though some are obviously more complex than others. As you know, the American healthcare system is struggling, healthcare costs are 50% higher than any other nation with outcomes that rank last amongst all industrialized countries. Patients and doctors are growing increasingly dissatisfied with today's care-delivery model. But the problems are growing rapidly than the pace of improvement. Two axioms that proved true in business in general, and healthcare in particular, are that strategic thinking without action is powerless and that a good strategic plan, well implemented, proves far more successful than a great one implemented poorly. With that in mind, let's begin with your book, Switch and the change process itself. What's one idea readers have found most useful in their change efforts?

Chip Heath: First, let me say thank you for reading all my books. I think you and my mom and dad maybe the only readers that have read all four of them. And I'm not sure about my dad, actually. So, let's start with the idea, the metaphor that underlies the book, Switch, which is recognizing that psychologists have for years talked about the analytical part of our brains that decides, you know, we need to change and assesses the need for change. But then there's an emotional side of our brain that has different ideas and may or may not come along for the ride. So, we decided we want to better beach body come summer, but then we open up the cupboard and see the Oreo cookies and that emotional side of our brain really wants to Oreo cookies.

Chip Heath: And the metaphor that we use in Switch is from a psychologist named Jonathan Haidt, he teaches at NYU, and he says that, that emotional side of our brain is like a big elephant. The elephant is being ridden by a tiny human rider and that represents the analytical side of ourselves. And what I love about his metaphor is that in the entire history of thought, because people have talked about this for years, Freud talked about the Id and the Ego, and Plato talked about a charioteer trying to rein in an unruly horse, but only Jonathan Haidt gets the relative weight classes right about these two sides of ourselves: the emotional elephant is the big player and outweighs the rider by a couple of tons. And so, change is more likely to happen when we align those two different sides of ourselves.

Chip Heath: So I don't know what the application is of that for medicine, specifically, but I think there are a lot in terms of doctors, you know, feel more comfortable with the way that we've done things before. And patients certainly struggle with the elephant and the rider when they embark on the procedure process, trying to eat healthier, exercise more. And so a lot of the chronic diseases that we face

are going to be changed by a patient behavior change, and that's got to grapple with the elephant and the rider.

Robert Pearl: I love that imbalance between the rider, at a couple of hundred pounds, and the elephant, at a couple of tons. Doctors take care of patients. What we know is that wellness is a tremendous opportunity and for the reasons that you say. It's difficult to get people to do the things that are going to improve their long-term health. What kind of approaches might you suggest that physicians think about, rather than just handing them the recommendations from the national societies?

Chip Heath: Well, I think one principle that we found in the book is that, very often, because the elephant is easily demoralized, and if you lay out the entire change that needs to happen, you can easily get an elephant that looks at it and says, "I'm not able to do that." And even if the rider is on board and understands the implications for my health of not exercising or not eating better or not losing some weight, that elephant coming along has got to be part of the process. And so one of the things that we find is that shrinking the change actually works better, in a lot of cases. So one of my favorite studies is a study of hotel maids and he asked hotel maids, "How often do you exercise? And 60, 70% of them say, "I don't exercise it all." Yet, if you think about their job, what they're doing is exercising. So every time they're vacuuming the floor, they're exercising. Every time they're scrubbing down a shower stall, they're exercising. Every time they're changing bed linens, I mean, they get more activity in a day than most of us do in a week. And so, one group of researchers went in and told a randomly selected group of maids, "You know, by the way, your work meets the Center for Disease Control guidelines for an active lifestyle, you're already an exerciser."

Chip Heath: And if you follow that group relative to a control group that was just asked to participate in a research study and take some measurements and fill out some scales at a couple of different points a month, the group that was told, "You're already an exerciser," they've lost an additional two pounds in the course of the next month. They weren't eating any different, they weren't going to the gym more often. But I think what they finally did is they realized that I am exercising at work. And if you take pride in that and glory in that during the day, you're going to be more enthusiastic about vacuuming, you're going to be more enthusiastic about changing bed linens. I mean, I got excited by that study because one of my tasks at home is to wash the dishes at night. And so now it's kind of a little Olympic event for me. I'm lifting plates up into the cupboard and I'm putting plates down into the dishwasher and I'm scrubbing the plates. And so, if you see what you're doing as exercise, it opens up a world of possibilities that wouldn't have been there earlier. And again, I think the advice that we give to patients, very often in situations where they're having trouble, is do everything better. And that's not necessarily the advice that's going to get past the elephant.

Robert Pearl: How would you modify it to get past that elephant?

Chip Heath: I think what shrinking the change says is just tackle a smaller change knowing that momentum will build if that smaller change is successful. So I have a friend that runs a wellness magazine, and she has what she calls a one-song workout. So she says, "Even though I know better and I know this stuff is really important, there are times when I just don't want to work out. But if I can force myself to put on my clothes and go to the gym and tell myself, 'If after one song I'm not into the workout, I can go home.'" And she says, "Almost inevitably, after I get my clothes on and go to the gym and work out for one song, I'm into the process and it gets fun and it gets reinforcing." But that shrinking the change is really important for her to motivate herself, her elephant, to get off the couch and go do the workout. And I think the advice that we give to patients, if we're a physician, it we're a nurse, has got to be more cognizant of the fact that there is that emotional elephant and shrinking the change sometimes is the best way to appeal to them.

Robert Pearl: Let's move on to another area. What's another key point that you've learned through your research and in Switch?

Chip Heath: Probably the single concept that has been most useful for people in Switch is when we approach to a change situation, things may look grim, but even in the grimmest situations there are bright spots. There are some people that are already making progress on making the change. And so, in the business context, a business person will look at during a recession, you know, our sales are down, they're down really strongly in the southeast region and so we tend to go focus on the southeast region that the people that aren't selling. But that doesn't tell you how do you solve the problem of selling in a recession? And what bright spots analysis is, is that instead of directing yourself towards failing in your environment, trying to fix what's failing, look at what succeeding and see if you can scale that success. And so almost inevitably, even in the middle of a recession, there's somebody that's selling more than everybody else. And if you go follow that person around you find very practical suggestions for how you turn around the rest of things. And so instead of focusing on the bottom 20% of the distribution, focus on the 90th percentile people and see if you can teach the 50th to the 70th percentile people to do what the 90th percentile people are doing. And very often that one technique unlocks all kinds of room for improvement and gains. But we have to overcome a strong tendency for the elephant that, there's lots of research in psychology that says we focus on problems, we focus on failures, we focus on what's not working right. And the elephant's attention is automatically directed there. And if we manage to overcome that, then all of a sudden, all kinds of resources become available.

Robert Pearl: I remember from your book, a great story, maybe you want to tell the listeners, about an individual named Jerry Sternin.

Chip Heath: Jerry Sternin was asked by his workplace, Save The Children, to go spend some time in Vietnam trying to work on the problem of malnutrition among Vietnamese rice farmers. And Sternin shows up at the airport with his wife, Monique, and their 10-year-old son, Sam. None of them spoke Vietnamese at

the time. The official that meets them there says, "You know, Jerry, we're really thrilled that you're here, our group within the government, but unfortunately there's another faction of the government that's not thrilled that you're here. It's a little embarrassing that we can't solve this problem on our own. And so we think we've got six months that we can give you six months of cover and support. But we better show some results in six months." Now Jerry Sternin had been asked to solve the problem of malnutrition man very, very poor rice farming families. And there was some conventional wisdom about what it would take, and it would take refreshing human capital and teaching people the theory of nutrition and, you know, fixing the roadways so that the farmers grow crops other than rice and get them into the urban areas where they sell them at a profit. And none of that was likely to happen in six months.

Chip Heath: And so, what Sternin did is we went to a village and he convened a meeting of moms and you say, "Would you like your kids to be healthier?" And that's the situation where the elephant is perfectly aligned. The moms say, "Yes, definitely." They say. "What do we do, how do we do that?" And that's a rider question. And unfortunately, the rider commonly looks at problems, in this case, what Jerry Sternin said is, "Let's focus the rider on what's going right." And so they had the moms in the village go out and collect some data about kids height and weight. And Sternin convened the meeting again after they collected the data and says, "Are there any kids growing up in the village right now that are healthier than the other kids?" And sure enough, they found some. And they started looking at them.

Chip Heath: And so, conventional wisdom in the village is that you eat two meals a day together, that you, as a parent, you offer your kids a bowl of white pure beautiful rice. And yet, the bright spot families that were raising healthier kids, they're eating four meals a day, no more rice than anyone else, but broken up into smaller meals. And instead of that bowl of white pure rice, they're mixing in sweet potato greens, which was commonly regarded in the villages as low-class food. They were mixing in brine shrimp, tiny shrimp that would grow in the rice paddies and adults would eat them because they added kind of a nice crunch and texture to the rice. But it was commonly understood that it's not a food you feed the kids. Yet, the bright spot moms were feeding the brine shrimp to the kids.

Chip Heath: And you and I can look at that and say we have a theory in nutrition, it says what those moms we're doing was adding protein and vitamins to their kids' diet, but the moms didn't have to have an elaborate theory in nutrition, they had a practice, and that practice worked. If you look at that, you think, I can scale that. And so they started bringing together groups of families who wanted their kids to be healthier. The price of admission was you come cook a meal together every night for seven nights, and you show up with a handful of brine shrimp and sweet potato greens. And the other moms learned from the bright spot moms how to cook the rice with the new mix-ins, and the kids get used to eating it with the weird crunchy stuff, and they're looking around and nobody else is dying, so must be okay. And so at the end of the week, that group

families can disband and they've learned a new practice and another group of families come together.

Chip Heath: And so within six months, 66% of the kids in that village were measurably better nourished and that's the bright spots promise. And so what happened, following that, is other villages around heard what had gone on in the first village and they said, "Can you teach us to do what you did?" And the answer was almost never again brine shrimp and sweet potato greens, but in every village there were families that were raising healthier kids, given local ingredients, given local practices. If you looked at what those families were doing in that village, you can scale that and make the kids in that village healthier. And in total, this program ended up reaching over 2 million people in Vietnam.

Chip Heath: And I think this is the single most stunning story that we found in Switch. And it happened because Jerry Sternin was smart enough to go into a situation that looked hopeless and instead of looking at what was going wrong he looked at what was going right. He said, "Can I scale this?"

Robert Pearl: Very applicable into healthcare, Chip. I think of how we handle data, outcome data, and how often we're so afraid of embarrassing people that we actually blind the data. We don't really tell physicians how they're doing, relative to others, or tell them who's doing the best. And so what you see is tremendous variation, you see some of the best organizations in blood pressure control getting over 90% with national averages down around 55%, the number one cause of stroke. 40% of strokes are caused by hypertension. And if we could improve the performance to match the best, we could save people going through that nightmarish experience. And yet, we often will hide it. The experience in healthcare has another facet that I appreciate your input around as well, however, which is that unlike the moms whose elephant, as you say, well aligns with the health of their children, physicians sometimes have a very emotional response, which is the data is wrong. How might you think of helping leaders to be able to coach and coax their colleagues into accepting the data, finding those outstanding performers, the positive deviants as you described them, and getting them to actually change their behavior, rather than defending the status quo?

Chip Heath: I think there's a tail of the distribution that's almost never going to be motivated. And I think one of the things that I learned in talking with people about change is because we focus on the problems, our focuses almost inevitably drawn towards the ones that are the most recalcitrant, the ones that are most behind the curve. And yet, I think there's a tremendous value in taking people at the middle of the distribution and saying how would we move the 50th percentile up to the 90th percentile? Because people at the 50th percentile are there because they're doing a good job, they're wanting to do what's right, and if you point it out to them, you know, "If you did this and this and this. If you fed your kids the brine shrimp and sweet potato greens, they're going to get healthier." And I think moving the 50th percentile up to the 90th is much more productive, much more effective, much faster than trying to battle

the bottom 20% who have agendas and personal things that may be in the way for them to move. But then when the gap widens between, the whole distribution has now shifted up from the middle up to the top, and I'm down at the bottom 20%, I think then social pressure kind of kicks in the other direction and motivates those people to either change or leave the organization.

Chip Heath: And there may be a point at which leaving is important. So, there's a joke, joke in science, came from the time period where physicists were being introduced to quantum physics ideas and there was an existing infrastructure of physics professors that just couldn't quite believe that. And Neils Bohr, one of the early physicists, said, "Well, science proceeds funeral by funeral." And what that meant was, we may have to wait for the old guard to die off before we convince everybody else, but all the young people in the field are going in the right direction. And I think we don't need to necessarily wait for the recalcitrant group to leave the organization. I think in some cases, we want to move around them and let them sit and realize the distribution is moving further and further away. And, hopefully, that'll make them want to change.

Robert Pearl: There's certainly a lot of data out of social media that indicate that as you reach a critical mass of people doing the right thing, that even the people who are the laggards will come along and join on, as you say, in almost all cases.

Jeremy Corr: There are organizations out there that Robbie, for example, in his book, calls the legacy players. Organizations that it's in their best interest to have healthcare stay the way it is, stay in its current broken state because in its current state, it is most profitable for these legacy players. It's not in their best interest to fix healthcare or improve upon the way the system is now, even though the people working there know that maybe what they're doing is wrong or maybe it's the right thing to do to help fix it. How do you encourage these organizations to do the right thing and not just stick with the status quo, even though it might be in their best financial interest to do so?

Chip Heath: I think my answer is it's going to be very hard to convince somebody, you know, to go for the $50 that their practice is entitled to from preventing some problem, a heart attack, when there's $5,000 on the table for treating the heart attack that's there. I mean, it's just when you get something that's that contrary to self-interest it's going to be hard to get people excited about preventative medicine in that situation. But I think what I would do is start with the people that are most likely to buy that message and not tackle the strong encounter, personal incentives folks first. And then if we change the standard of practice for things because we've got a lot of people that don't have the wrong incentives, who are willing to make the change to do something that's better for the patient, better for the system, better for the country, and the population, I think I would pick my battles strategically so that we do the easy things first and then try to hope that social dynamics and social pressure bring on the harder cases or cause change in the incentives that we've set up for the other folks.

Chip Heath: And I think one of the things that I see is the most common mistake of people in change situations is people in organizations will say, "Such and such person or group is so dead set against this that we really want to understand more about how to tackle them and how to change their mind." And my response is, "Do what armies do in warfare when you have a strongly reinforced city, you don't tackle that city first, you go around it and you tackle the other cities and then you come back in and deal with the stronghold of the opposition when you have more resources available and more time available to work with it."

Robert Pearl: Maybe one more free Switch. Give me one more great idea, Chip, that you've found that you consulted with hundreds of businesses around the United States and across the globe.

Chip Heath: I think one of the main things that we find is there's this argument between the elephant the rider. And the third part of the model that we have is the path. There's a path to making things more effective. And I think so often in life, there's a common mistake people make that has kind of jargon psychology label, it's called the "fundamental attribution error." And that is to say that when we see somebody not changing, when you see somebody not doing the right thing, we attribute that to the person's character, their genetic flaws, their lack of motivation. And really in many situations, we don't have to change people's character, change their motivation, we just change the environment.

Chip Heath: And so for example, Amazon has a patent on one-click ordering. And that's astonishing because you'd think this is an obvious business idea, just make it as simple for somebody to check out as possible and boil that down to one click. And yet patents can only be awarded if nobody in the history of the universe has ever thought of something before you think of it. And this has been a controversial patent, but it stood up. Nobody in e-commerce, other than Amazon, took the time to take away every barrier between the customer and the purchase to make it as simple as one click.

Chip Heath: And so I think of situations in hospitals where simple changes in procedures might make a big impact in facilitating progress. So, some hospitals have adopted a technique from agile programming, where you have a stand up meeting at the beginning of the day to talk about a patient who's close to discharge and what needs to happen between now and then. And hospitals that have adopted a simple quick meeting at the beginning of the day, with all the disciplines presented and found that they could shave a day or so off of a three-day hospital stay. And the patient goes on happier and the hospital has freed up resources to bring somebody else in. And that happens because we adopt a simple change in procedure to kind of "one click" our meeting. It'd be nice to have most hospitals would sign up for one click discharge process. And the hospital manages to do this going to have a patent that, I'm joking, but be the equivalent of the one click patent for Amazon if somebody could actually master that process.

Robert Pearl: Physicians with love a one click discharge process, it's so complex right now. They would love to be able to accomplish that in the speed that you're describing. Let's go on to another book. Tell me a concept, a principle, that you think has proved very successful from one of your other Washington Post and New York Times bestsellers.

Chip Heath: We have a book on decision making called Decisive, and one of the concepts that's most useful in thinking about how people make decisions and what problems they have is a phenomenon known as confirmation bias. And the idea with confirmation bias is that when we're making decisions, we tend to favor, implicitly and kind of unconsciously, information that supports our case as opposed to the information that doesn't support our case. So, there're dozens of studies of this and, on average, there was a meta-analysis that came out a few years ago, looked over hundreds of these studies, and on average, what people do is they're twice as likely to favor information that supports their view as information that doesn't. And from the standpoint of the decision maker, they're being even handed, they're looking at the information that is in favor of their case and against their case. If you're a Thai food fan and you have a new Thai food place moving into your neighborhood and you really, really would like that to be a nice Thai food place, it turns out you will read twice as many five star reviews as you will read two star reviews.

Chip Heath: And for the Thai food place it may not be a substantial problem because you get your Thai food, but if you're smoking, in the 1950s we ran lots of studies with smokers, and we found that they were twice as likely to read an article that is associated with a headline like 'smoking found uncorrelated with lung cancer' as opposed to reading the articles with the headlines that 'smoking is found correlated with lung cancer'.

Robert Pearl: I think what you're describing very much relates to how slow change happens in healthcare. The RAND Corporation analyzed great ideas and found that it takes 17 years from their conception to implementation. You know, the history of infections, Semmelweis, centuries in the past, was able to lower the infection rate in women giving childbirth. Everyone knew it. In fact, all the women came to his clinic rather than the alternative ones, and the physicians of the time continued to believe that the problem was bad air. We saw that with Barry Marshall, who won the Nobel Prize in Medicine for proving that stomach ulcers are caused by an infection from H. pylori, not from stress or spicy food. And yet, I can think of multiple problems that exist right now that possibly the confirmation bias is there. The question of hand washing, physicians see themselves as somehow not capable of carrying bacteria, the confirmation bias is none of my patients got sick last week, last month, so therefore, what I'm doing is fine. The data says people are dying and the hospital acquired infections as their leading cause. Pick one of them and tell me how you might approach it given the fact that the decisions we're making today are not good ones.

Chip Heath: Yeah, I think in general the solution to confirmation bias is you get people to focus on disconfirming evidence and that's hard. And so I think the hand

washing is a difficult situation. I saw an example of one hospital that had tackled this in their hospital. They walked into a brown bag lunch that doctors were having in the middle of the day and brought culture plates. And basically everybody put their hand they were eating their turkey sandwich with on a culture plate and cultured the bacteria and stuff that were on their hands. And there's a shocking image that ended up being used as a screensaver in the hospital with just a hand in all the different organisms that were cultured off that hand, there were devastating bacteria of various kinds. And I think that kind of disconfirming evidence of, you know, even when we think we're doing things effectively, this is what our hands look like. I think that might be a way of getting people's attention in kind of a vivid way.

Robert Pearl: Along those lines, do you think if we had on cigarette packs gruesome pictures of patients with amputations and tracheostomies that that would make a difference?

Chip Heath: I haven't looked at the data on cross cultural smoking rates, but there're certainly cultures that have more effective graphics on their cigarette packs than we do. Our typical warning is 'the Surgeon General has determined that cigarette smoke contains carbon monoxide' and, you know, that's kind of a lesson for not the elephant but for the riders that remember 10th grade chemistry class. There are other cultures that have more effective messages for the elephant. So in Italy, the cigarette pack warning is half the pack and it says, 'smoking kills'. It feels more like an elephant message. In Canada, they'll show 17, 16 year old girl, a picture of yellow ugly teeth and say, you know, "smoking contributes to mouth disease and various problems." My favorite is the Canadian, they have a picture of a cigarette that's kind of drooping in a suspicious way and they say "cigarette smoking causes impotence." And I think there's any tool that be likely to reach this 16/17 year old boy that's thinking about taking up the smoking habit, that might be the message that would reach the elephant.

Robert Pearl: How about another idea from one of your books?

Chip Heath: Let's talk about the Power of Moments. So we wrote a book that came out last fall, fall a year ago, and were focusing on how do we create experiences that people value? And so one of the things that we got to do that was a real luxury is as people what are the most important moments, what are the defining moments for your family, or for career? And one things that we find over and over is that there are certain properties of those moments that are powerful for people. So moments that are intense sensory experiences. So sitting at the National Park and looking at the amazing view, the Grand Canyon or the arches, looking at a fireworks show, the birthday party with the sweets and the cupcakes, you know, those are intense sensory experiences. Another one that matters is insight. And so, times when we realize this is not the job for us or that's the person I want to marry or, wow, I've been doing my business this way and I really should be doing it that way.

Chip Heath: So what we've been encouraging people to do is to build these things into their work. And I think for a hospital, for example, the notion of sensory experience is absent in most hospital stays. So if you think about the process of just trying to go to sleep in the hospital with the buzzers and the beeps running around, I've seen hospitals that have tackled the sleep cycle by bringing a cart around at night and giving people lavender scented hand cloths to rinse their hands in bed and pat their face as they're going to sleep or serves them a cup of chamomile tea or gives some earplugs for avoiding the alarm sounds in the middle of the night. I think those are basic things that make for moments that matter to people in a difficult a situation.

Jeremy Corr: Talking about the Power of Moments, when someone goes to a doctor or a hospital, they expect perfection. It's almost like a Marriott type of experience where they expect perfection and perfection won't necessarily get talked about. Nobody goes on a website and leaves a review unless something that soured the experience or something that really went above and beyond the experience impacted them. For example, when I was a day old, I was rushed to the University of Iowa Hospital for emergency surgery and spent the first few months of my life in the hospital, and there was a nurse that really connected with my family and made the experience as easy on them as possible. My family's still talks about this nurse every time my, you know, my experience as a baby was talked about. And she's still a close family friend to this day. How do we make moments like this more common?

Chip Heath: There's an element of connection that we find in defining moments across domain. So when you ask people about their work experiences, what are the most important experiences? They often have an element of connecting across with somebody, somebody that I didn't know I would enjoy or get along with. We talk about family events, sense of deeper connection that we got because we talked about this issue that had been on the outskirts of what we found permissible to talk about, but suddenly had this breakthrough and we could talk about this sacred cow that we needed to address, but we hadn't addressed before. So, time and time again the moments that people talk about is defining moments in their lives and their careers and their families are these moments of connection. It could be as simple as giving people, you know, a little bit of information about a patient, other than that they've got a particular medical condition.

Chip Heath: And so, I remember hearing somebody talking about buses in São Paulo, another city in South America that the bus drivers were feeling kind of isolated and they're having a lot of turnover among bus drivers, until they did something as simple as have for each bus driver, have the soccer team that they followed, have the ages of their kids. And all of a sudden, passengers when they would come on would joke with the person but how their soccer team had done the previous weekend or say something about "Oh, parenting teenagers, I'm sorry," and offer my sympathy. And so, providing those ways of people connecting beyond the function in the workplace environment, I think is key.

Chip Heath: And so it sounds like you had somebody that was just naturally gifted at that. But suppose we wrote it on the whiteboard a few facts that foster conversations, beyond the status of the monitors that were beeping and the electronic medical record that has to be updated, I think that would be a start towards what you're talking about. But I don't think we try to engineer those situations as much as we try to engineer having the right 13 monitors hooked up to the patient.

Robert Pearl: One of the big issues in American healthcare today is end of life care, palliative care, being able to have these honest conversations with patients. Given what you learned in the book, do you have thoughts about how to make these experiences, these very difficult, negative experiences, sometimes, become ones that add value to both the patient and their family?

Chip Heath: What I've read about that field is that they're already brilliant at creating these moments. And I think one of the things that could work even better is more just talking between people that are currently doing palliative care and physicians and nurses that are referring families to those services. Because I think they're brilliant at helping families see, "You know, here's the progression that is going to happen to your loved one." And, you know, for example, one of the things that often scares people and families and relatives is that the loved one who's going through the final stages will start hallucinating and there'll be events that come up from earlier in life and they will mis-recognize people in the family and they will have conversations that are kind of strange.

Chip Heath: My wife's dad, when he was going through this process, was remembering being on a submarine and, in fact, he had never been on a submarine, but it was a very vivid illusion for him in the last week of his life. And luckily, my wife had contact with palliative care nurse and the nurse said, "By the way, you know at some point, your dad is probably going to hallucinate and he may mis-recognize you, he may miss remember things from his life, but know that that's a common part of the process and it will last for a couple of days and then it'll go away." And so when it happened, my wife is in a better position to roll with the punches and understand that that was a part of the process.

Chip Heath: There's a great book by Lewis Thomas called "The Youngest Science" where he talks about medicine as a field. He became a physician after his father's footsteps, but his father had grown up in an era and become a physician in an era when medicine didn't even have antibiotics. And what physicians did in his father's era was more of this provide insight to the families, "Your loved one has the following disease or infection, you know, here's the prognosis, here's the time course of what's going to happen." And just telling people, telling families and telling patients, "Here's what you've got. And here's what's going to happen." Those moments of insight were tremendously valuable to make physicians very valued members of society, even though they couldn't cure things like we can today. And so, taking into account the fact that insight is powerful motive for people, I think that's a strength that medicine has that it doesn't always exercise.

Robert Pearl: As you point out for most of history physicians had almost nothing outside of some very minor surgical things that can be accomplished in under two minutes because that was the limit of patient tolerance for pain. Abraham Verghese, in his multiple books, talks about this type of experience back in the early days of AIDS, as an example, and that a power of that physician was to be able to provide comfort, to provide solace to families, was so powerful that, as you say, that physician was held in high esteem, despite the fact that the impact that physicians could do was minimum. We've forgotten that. And I think that's a crucial piece for American healthcare to bring forward, particularly with the data that we have on physician dissatisfaction, so-called burnout, with a third of physicians reporting being depressed, the opportunity to be able to bring back in those values, I think are going to be effective, not just for patients, but physicians as well. One of the things I really enjoyed in that book of the Power of Moments, was your story about the gloves, could you tell the listeners that story?

Chip Heath: One of my favorite stories of change is a story about a man in a multinational manufacturing firm. He was the Vice President of Supply Chain, and this is a position that you get to go to the senior management meetings, but you're not the chief financial officer, you're not the CEO, you're not the COO, so you're not really part of the central core of the team. And he was thinking, "We've got inefficiencies in our supply chain that we really ought to tackle." And I know what I would have done in his situation, I would have gotten a 30 slide PowerPoint deck put together in a 12-tab spreadsheet and tried to prove to people that, you know, inefficiencies in the supply chain is really an important thing to think about.

Chip Heath: And what this guy did was much savvier and smarter. He picked one product category that everybody could understand, all the factories around the world employed gloves to protect the hands of their workers as they worked. And he sent a summer research associate to track down how many different kinds of gloves are we ordering in this organization. And the answer was 424, which was kind of a shocking number to everybody that heard it. But he did one better. He asked the associated to go track down and buy one of each pair of gloves. And so he collected all the gloves and he brought them in boxes and mounted them up in the conference table where the senior leadership team would meet. And he invited his colleagues one by one to come witness his glove shrine. And they would come in and they would see this stack of gloves on the table and walk around the table. And eventually they'd turn and say, "You mean we're really buying all these kinds of gloves?" And he'd say, "Yeah." And then the person would notice there were price tags on the gloves. So they'd pick up various pairs and eventually they'd hold up a pair and say, "You mean we're really paying $3 for this set of gloves and $11 for that set of gloves, they look pretty much identical?" He would say, "Yeah."

Chip Heath: And so, he said there are two reactions that people had. First one was, "This is crazy. You know, why are we buying 424 kinds of gloves?" And the second reaction was more of a reaction of hope is like, "We can fix this. You know, we

could buy three kinds of gloves that will span the use and situations that we need. And let's source them all from the suppliers of the $3 gloves, they look like they make a good product for an inexpensive price." He said, what happened in response to that is people would say, "Well, you know, gloves really isn't the issue here. Unless we're paying $15 for a pair of gloves, but we have things in our production process are costing us hundreds or thousands of dollars. Why don't we fix our supply chain."

Chip Heath: And so, suddenly, he had a group of people that probably wouldn't have been concerned about the supply chain concerned about the supply chain in the midst of all the other decisions that they had to make about global economic recessions and market entry into China and he got them thinking about his issue. Because he was smart enough to come up with an emotional, credible demonstration that was simple enough for anyone to understand, that would enable them to take off in their own mind and use that as a springboard for thinking about what really is important here.

Robert Pearl: As you talk about that, I think to the operating room where what exists in most hospitals is what we call physician preference cards. Each physician who does a set of operations, maybe say 20 operations, has a list of instruments that he or she likes to use and little suitcase size instrument sets are created. Sometimes with 100 different instruments in them through the use of that particular individual on the day of surgery. What that means is that if you're going to be doing several of these operations, someone, by hand, has to now assemble your particular set of instruments. And often my set and your set will differ by four or five different clamps or different forceps. It's just like the gloves. If we could all agree on a common set of instruments and if I can do the operation with a particular clamp, why is it that you can't, if assuming it's the same operation. Think about it, how much greater availability there would be, how much less costs there would be, and of course for the staff, how much greater comfort and quality because they're using the same piece again and again and again.

Robert Pearl: A good example again, going back to Kaiser Permanente, is that we looked around and we saw in orthopedics that physicians were using five, six different types of total joint implants, remember for every implant you need a small, medium and large, a left and a right, the amount of space that was being stored, the inability to understand whether all the implants were in place. We said to the physicians, pick two, amongst all the orthopedic chiefs, pick two, it doesn't matter which to it's going to be. And we were able to not only dramatically lower cost by better negotiation, obviously, but raise quality and improve staff satisfaction. The nurses who weren't quite sure what was happening in the operating room because they'd never seen this unique particular implant had now done three of them the day before became more expert at it. That visual display, I think overcomes, as you say, so much of the rider's intellectual sense of what's going on and the visual display, to me, is very much an elephant type of response.

Chip Heath: Yeah, if you'd walked in with pictures of, you know, for the five different surgeons that we have and the six different operations that we do commonly, here are the 30 different trays that are laid out every time, I think that would be a tremendous, tremendous example of the glove shrine that this guy built.

Robert Pearl: Hopefully, one of the listeners will try it in his or her hospital and let us know how it goes. Give us one last idea out of the research, you know, you're a PhD, you're a professor, you're a writer. What's something you're working on now and exploring that readers can learn from because it's not yet in one of your books to your next book?

Chip Heath: So one topic that Dan and I have thought about a lot is silos problem in organizations. And I understand you have a few of those in medicine. Atul Gawande, I was listening to a while back and he said doctors have an arsenal of 6,000 drugs and 4,000 procedures to attack 13,000 diagnoses that are known to medicine. And in any situation like that what organizations do is they divide up task into domains and allow people to specialize. So a car company has marketers and engineers and production people. And very often, once you do division of labor, you train people and reward them in different ways and they come up with different points of view on an issue. But then at some point you've going to integrate them all together. And that integration part is what I think is the fascinating problem. It's how do we integrate effectively people from different points of view, different formats. And so I was talking with the group from one hospital, they were talking about certain patients that are kind of frequent flyers, they have complications that are multiple systems, they'll have seven specialist physicians that work on the different facets of their condition.

Chip Heath: But what seldom happens with these patients is the families get together in a room with all of the people who are involved in the care of, this is actually a children's hospital, so parents getting together with all the physicians that encounter their child. And what they found is that having one simple meeting where they would talk through the treatment course together as a collective, they would exchange information about, "Here's how to contact me. Here are the best times, here's my preferred form of contact," that one simple meeting would lead to very quickly, for a patient that was running $3 million dollars a year in procedures, it would easily take off half a million or a million. Because the physicians were able to coordinate when something looked like it was going to be a problem, to coordinate treatment so that the patient didn't end up hospitalized. The physicians were in a better position to contact the parents because they hadn't realized that the parents didn't have easy access to email, for example. So I'm fascinated by situations where we have a division of labor and we need to coordinate more effectively what are the mechanisms and especially simple mechanisms, like the joint meeting, that enable people to solve these problems of communication across silos.

Robert Pearl: As you talk about that, I think you're highlighting a very important part, which is that medicine has become so complex that it requires a multispecialty, and I

don't mean just physician specialty, all the people who are going to be touching a patient in a particular interaction to come together to coordinate things in a way that will lead to better quality at lower cost. I think of the experience around total joints. You know, if you asked how do we move the post-surgical stay from where it was a few years ago, which was three days or longer, down to an outpatient, you probably would tell me that's just not possible. And what I'd say is today, surgeons in Kaiser Permanente 60% of the time are sending patients home the same day. You may say, "Oh, it must be the surgeons." Well, the surgeons need to participate, there are things they need to do intra-operatively, particularly around the injection of long-lasting anesthetics into the capsules around the joints itself.

Robert Pearl: But how about the health educators who have to in advance make sure that the patient understands what's going to be necessary. Organizes their house so the right food is there, so the right ramps are sitting in place. How about the physical therapists who has to actually start moving the patient in the recovery room, and actually does even better if they start before surgery, strengthening the muscles to get them as strong as possible so the patient can then ambulate quickly afterwards. The anesthesiologist, the primary care physician, you go down the list of individuals, and by bringing this team together as you're describing to get better collaboration, coordination, that opportunity is to raise quality, to lower costs, to make care more accessible, all the things that we want, that Don Berwick talked about as the triple aim in the last season, start to happen. One of the things I heard you once say is that all change comes because people say one of two things: This is wrong or this is really cool. Could you expand on that for our listeners?

Chip Heath: We commonly think about the elephant as the bad guy in this conflict between the rider and the elephant because we're analytical people. We got into a field, I'm an academic Business School professor, you're a medical person, but both of us take the same analytical approach to problems in our respective fields. And so the rider is always venerated as the good guy in the interaction. And yet, if you think about why change happens, it's very seldom that riders analyze their way into a change. The elephant has an elephant reaction of, you know, that's wrong, that's wrong that we're treating people that way. Or, that's really cool. What if we could do this? You know, so every Nobel Prize that's ever been won has been won because somebody's elephant said, "That would be really cool to understand calcium iron transport across the boundaries of cells." Now, for the non-former chemistry majors out there, that may not be your elephant appeal, but the fact is that most things that happen that are positive in the world, great companies get built, great science gets done because somebody has an elephant reaction, that's really cool. And so I think we can't ignore the elephant, and especially in incentive, we're attempting to do with economic incentives what passion very often will do even better. And so, to create great, great change, we want to integrate not only the rider, the analytical side, but the elephant, as well.

Robert Pearl: My sense, Chip, is that not only do we overvalue that rider, but we often try to hide that elephant. I think as soon as we start saying in American medicine this is wrong. It's wrong that people should be dying unnecessarily from strokes that can be prevented. It's wrong that women have an increasing childhood mortality rate in the United States. It's wrong, the opioid epidemic. It's wrong that we're able to watch life expectancy in United States drop. It's wrong that healthcare's become unaffordable. I think once we truly embrace that elephant, that change can happen. As we like to say on this show, we can make American healthcare once again great.

Jeremy Corr: A lot of consumers in American healthcare don't feel empowered to shop around for their services the same way they do when they shop for something on Amazon or at Target and find the best price and most convenient product for them. This may be because it's more difficult to shop around in healthcare. But how do we encourage and empower patients and consumers of healthcare to take control of their own healthcare experience?

Chip Heath: I think that what might help here is just some extreme examples of the principle and circulating those stories more broadly. So, there are procedures now that are cheap enough, that sort of paying for a heart procedure here, I could go to Thailand and spend a three week vacation there with several members of my family and spend less money, having a very effective surgeon do it in Thailand than to do it here. Collecting the stories, telling those stories, having patients think about there are alternatives out there. I think those are going to be effective at least shifting some people towards being more active consumers.

Jeremy Corr: Well, Chip, we've taken up a lot of your time today. Is there a closing statement with takeaways for both industry leaders and for the average healthcare consumer that you would like to offer? You may also ask them to follow you on your various social media channels.

Chip Heath: So, there's a website associated with my brother and I and the books that we've written, it's HeathBrothers.com. I think the thing I would leave people with is that even in the midst of difficult circumstances, the change is already happening. And change is already happening in the field, change is already happening in your organization. And our natural tendency, our analytical rider tendency, is to focus on problems and focus on places where things are going wrong. And yet, if we can redirect some of that attention to where things are going right, to look at the bright spots, at the situations where we're already starting to tackle the problems, those bright spots are going to occur in the industry but they're even occurring in your organization right now. And so, don't obsess about the bottom part of the distribution, focus on taking the best people and having them train the people in the middle of the distribution to be as good as they are. And that distribution is going to start changing in a way that will even bring on the laggards, bring on the recalcitrant people. And that, to me, is an optimistic message about the potential for creating change, even in a very difficult circumstance.

Robert Pearl: Chip, thank you again for being on the show today. Your ideas for making better decisions, engaging people and making change happen are breathtaking in scope. I'll remember the elephant and the tremendous mismatch in size with the rider. Like yourself, I have to admit, I tend to think of rider solutions, intellectual answers, before I think about the emotional ones, but as you've pointed out, the emotional ones are so much more powerful. I'll look for the bright spots and think about Jerry Sternin and his experience in Vietnam, changing the health of 2 million people, and the very, very powerful power of moments and of stories, to be able to make changes in organizations, entire movements across populations that most people thought was never going to be possible. I encourage our listeners to read your books. And I promise them if they follow your ideas they'll become better and more effective leaders, physicians, nurses, parents. In season one we heard dozens of great ideas to improve American healthcare. With the concepts you've offered today, we can begin to do so on behalf of patients and doctors, nurses, people everywhere. I don't know which of your ideas will prove most successful, but any listener who thought that changing healthcare was impossible, you've proven him or her wrong. I appreciate you taking the time and contributing your expertise to improving the health of our entire nation.

Chip Heath: Thank you so much.

Jeremy Corr: Next month, our guest will be Elizabeth Rosenthal, the editor-in-chief of Kaiser Health News. Prior to her current role, she spent 22 years as a correspondent at The New York Times. She's the author of the bestselling book "An American Sickness: How Healthcare Became Big Business and How You Can Take It Back." Her insights into surprise hospital charges and the impact on people will shock you.

Robert Pearl: Thank you again, Chip. And now before we go, let's take a few minutes to hear from our listeners. Back in December we asked for your ideas on how to fix American healthcare. We received over 200 responses and counting. You can still add your recommendations on my website, RobertPearlMD.com.

Jeremy Corr: Today we will hear from listeners who wrote in about the roles nurses play in providing care and improving the health of patients. Kate York wrote us about how nurses can keep patients from falling through the cracks of our medical system. She believes that every patient should have a nurse liaison to help with managing medications, appointments, etc. Fallon Brown believes that a lower nurse to patient ratio will decrease medical errors and increase bedside teaching. Fallon recommends that NPs be allowed to practice at their full capacity. Our final comment comes from listener Kelli Carderas who thinks that having nurses available in workplaces, schools and community social settings will not only increase access to care, but also ensure that patients are taken care of in a more culturally sensitive way. Robbie, can you provide the listeners with some of your thoughts?

Robert Pearl: Nurses are highly valued by patients and doctors alike and vital to our healthcare system. A couple of years ago I broke my leg in an accident that required major surgery. I spent the next three days in the hospital, and I can attest, personally, to the dedication, commitment and expertise of every nurse who treated me. I agree with our listeners, nurses can play the role of liaison and help patients navigate the confusing healthcare system. They can also educate people on opportunities to improve their health and lifestyle. And, certainly, nurses are capable of taking medical care out of hospitals and into our communities. Thank you to all of the nurses who listen to this show and care for millions of patients 24 hours a day, 365 days a year.

Jeremy Corr: And thanks to Kate York, Fallon Brown, Kelli Carderas, and everyone who participated in the Survey to Fix American healthcare. You can read all three listener comments on the fixing healthcare website. We also invite you to visit leave your own thoughts and recommendations at www.RobertPearlMD.com. Next month, we'll share more ideas and suggestions from our listeners.

Robert Pearl: Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you like the show, please rate it five stars and leave a review. Visit our website at www.fixinghealthcarepodcast.com. You can follow us on LinkedIn and Twitter @fixinghcpodcast. You can also find out personal social media accounts on the website. For additional information on other healthcare topics, you can check out my website RobertPearlMD.com. We hope you enjoyed this podcast and will tell your friends and colleagues about it. Together, we can make American healthcare the best in the world.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.