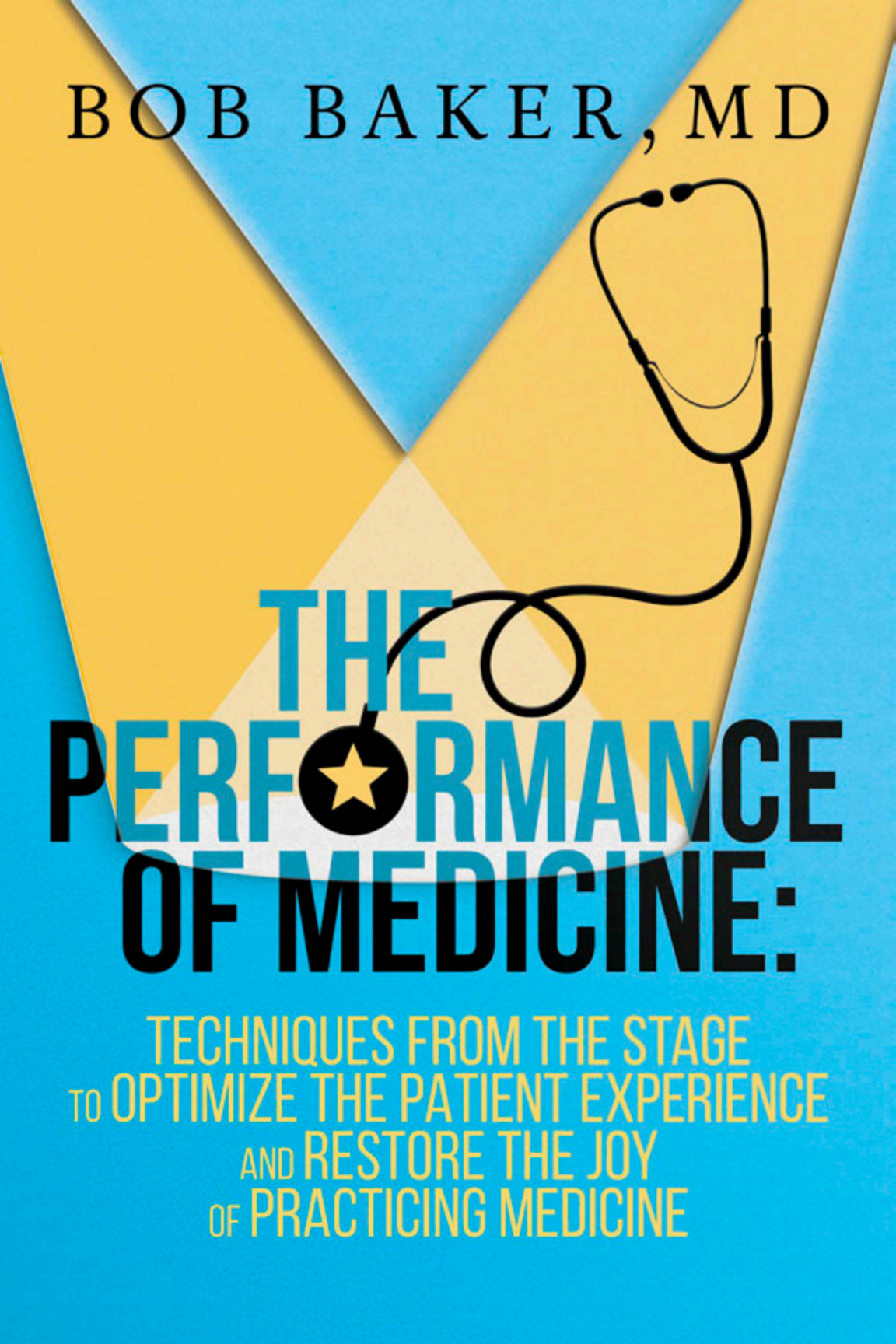
BOB BAKER, MD



THE PERFORMANCE OF MEDICINE:

TECHNIQUES FROM THE STAGE TO OPTIMIZE THE PATIENT EXPERIENCE AND RESTORE THE JOY OF PRACTICING MEDICINE

ADVANCED PRAISE

"Baker is a natural storyteller—a combo platter of Aesop, Garrison Keillor, Homer, and Bob Hope."

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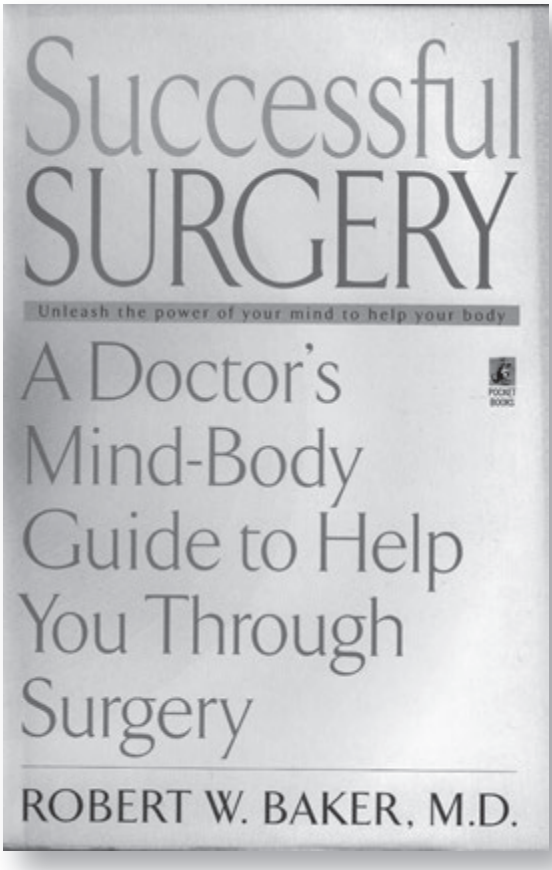

SUCCESSFUL SURGERY:
A DOCTOR'S MIND-BODY GUIDE
TO HELP YOU THROUGH SURGERY

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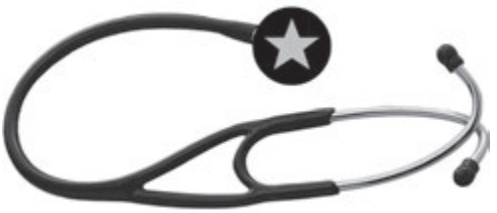
For my patients.
For the healers.

And for Marcia.



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FOREWORD

In April 2016 I had the privilege of arranging a presentation on patient experience by my friend Dr. Bob Baker for colleagues at my hospital. Before the date, we discussed how his presentation, titled *The Performance of Medicine: Putting the Patient Experience Center Stage* would explain how he uses his experience as a magician and ventriloquist to attain super patient satisfaction. I admit I was more than skeptical. I did not see how making a dummy talk or how smoke and mirrors could improve our Press Ganey scores. However, with his survey ratings ranking him consistently at the 99th percentile nationally, I knew he must be onto something, or he was practicing real hocus-pocus. Either way, I was interested and more than impressed at the end of his presentation when those in attendance said they were eager to put into practice the simple strategies he taught: techniques used by all performers to delight their audiences and which Dr. Baker uses to connect with his patients.

For thirty-five years, Dr. Bob Baker has been a practicing gastroenterologist in a competitive and demanding market where patient expectations go well past preventing and healing illness, and care experiences are judged equally on the quality of the interactions between caregivers and their patients. Dr. Baker has consistently received the highest ratings possible by his patients in reviews and on patient surveys. He has thrived in the modern healthcare paradigm using the performance skills he's borrowed from an even longer career onstage, skills he explains in this book.

Dr. Baker sets the stage by jocularly tracing his journey through the business of healthcare, which has changed dramatically since his days as a medical student. He starts before insurers became involved in

medical decisions and doctor reimbursement and continues through today, when the pressure is greater than ever to do more with less. In this new environment, doctors need to understand what patients want, need, and expect. Physicians must use skills they may not have learned in medical school to make every moment with the patient magical. No longer is it acceptable to deliver healthcare while focusing only on diagnosis and treatment, and with service pushed backstage and out of sight. Today, the entire patient experience is subject to review.

Dr. Baker approaches every patient interaction as a performance and shows, in this book, how doctors can incorporate the techniques used by every performer before, during, and after patient interactions to turn each encounter into a five-star patient experience. Dr. Baker borrows from his long career in front of large audiences to delight the small audiences in his exam room. His techniques are based on sound research in the field of service excellence by some of the most prominent experts on the topic of patient experience as well as from the accumulated knowledge of award-winning thespians.

I know you what you're thinking. You're not an actor. Well, rest assured, you don't have to enroll in The Juilliard School to become a better doctor or nurse. There's an actor in all of us, and you already have many of the skills needed to perform better in the exam room. You just need to use them, and Dr. Baker explains how, when, and, more importantly, why to use them in a straightforward manner that is easy to understand. With the essential points highlighted at the end of each chapter, this book makes it effortless to retain its central ideas, much the same way a competent practitioner discharges his patients with a concise list of the signs and symptoms to look out for. Dr. Baker shares plenty of anecdotes that will make you laugh as you read them, but the concepts presented are based on science, years of his personal experience, and plenty of trial and error.

The Performance of Medicine is primarily intended for doctors in outpatient practices, but the information and techniques work for

nurses, nurse practitioners, technicians, and in hospitals as well as in outpatient settings.

As a hospital administrator who has worked most of my professional life trying to improve patient satisfaction, I wish every doctor with privileges in my hospital would read this book and put Dr. Baker's techniques to work. They are easy to implement. They will not add more time to encounters, but they work like magic and will make every patient experience worthy of a standing ovation.

—Michael Maione
Director of Customer Relations
Stony Brook University Hospital

INTRODUCTION

We've all been patients too.

I was in my urologist's office, sitting on a small exam table where I was about to undergo an outpatient vasectomy*. Yes, I was a bit anxious. The visit up until then had gone smoothly enough. The receptionist was efficient, if not overly friendly, and a pleasant medical assistant had escorted me to the small procedure room and told me to remove all my clothes except underwear.

The minutes ticked by. This was years before I had a smartphone to distract myself. There were no magazines, even old, tattered ones, to look at. I had surveyed the contents of the room several times already. I had refreshed my knowledge of my personal anatomy from the anatomical chart hanging on the wall and was hoping it was not there for my doctor to refer to. Now there was nothing to do but sit and wait. And wait.

Finally, the door opened, and there stood the most severe-looking nurse I had ever seen. She wore a starched white uniform, and her steel-gray hair was pulled back in a bun tight enough to give her a rhytidoplasty.

She stood in the doorway for a few endless seconds and, in an accent reminiscent of Frau Blücher† from *Young Frankenstein,* hissed these exact words: "Take off your T-shirt. You're going to *sweat* a little." And walked out.

I nearly passed out.

However, ten years before that I had quite a different patient experience. On a Friday morning in 1981, Boston obstetrician Dr.

* Let's get personal right off the bat, shall we?

† https://www.youtube.com/watch?v=hs5j8uUR2nc

Kenneth Blotner ruptured my wife's membranes to induce labor for our overdue first child. It was Dr. Blotner's weekend to be off, but he agreed to induce "us," I guess because he recognized that the Bakers were a little bit anxious about childbirth and had only seen the covering doctor once.

So Dr. Blotner did the deed, started a Pitocin drip, and we waited. And waited. The labor progressed slowly. Twenty-one hours worth of slowly.

I recall very little of those twenty-one hours except being scolded once during Lamaze coaching/breathing for having "Frito breath."

One thing I will never forget, though, is that Dr. Blotner assured us, without our asking, that he—and not the covering doc—would be present to deliver our baby no matter when he arrived that weekend—which he did at 1:21 Saturday morning.

We moved away from Boston, and I'm sure Dr. Blotner forgot us among the many acts of kindness he performed in his lifetime. But we never forgot him.

All of us practitioners have stories, good and bad, about our experiences with other health professionals, be they doctors, nurses, nurse practitioners, physician's assistants, etc. The stories might be entertaining, instructive, harrowing, or all three, but they've just been stories. They didn't count for anything. Until now.

Today, patients report their experiences and rate us in surveys from health systems, insurance companies, and the government. They can post reviews about us online and grade us like hotels, restaurants, roofers, and plumbers*. Less than stellar ratings can lower our income, prevent us from attracting new patients, and even get us kicked off an insurance company's panel of providers. We *must* provide patients with excellent experiences.

That's why this book is necessary now. Our ratings and patient satisfaction scores are going to play a big role in our futures. If we're

* Actually, as a gastroenterologist, I don't resent being rated like a plumber. We sort of do the same thing. They just get paid more.

not getting top scores, we'd better perform better. *If* we perform better, there are the added benefits that our patients' outcomes will improve *and* we will enjoy practicing more—or again.

So: a book called *The Performance of Medicine*. Long ago I came to the realization that when any health practitioner interacts with a patient, it's a performance. Not a show, but a performance.* And by bringing into the exam room the skills that a performer uses to connect with and win over an audience, we can improve the experience for our patients and ourselves. We just have to learn how.

Keep in mind from the outset that the goal of any performance is to *connect with* and *communicate with* the audience. This is true whether the performance is Bruce Springsteen playing a concert for twenty thousand people or you telling a joke to a friend. And it's true when you are in the exam room or at the bedside with a patient. He or she is your audience. It is only through connecting with the patient that the magic of medicine can begin.

★ ★ ★

In our new world, which I'll discuss in detail in Chapter 1, the fact that we are good doctors with good results is no longer enough. As physicians, we've been trained to concentrate on outcomes. Does the patient get better? Live longer? Does he live at all? For the last century, those results have been pretty much what mattered to us. Yes, the humanist element of medicine has always been important, but now the concepts of "patient satisfaction" and "patient experience" are gaining prominence, and we ignore them at our own risk.

The risk is to our reputations, our practices, and our incomes. What patients think about us and what they experience in our offices and hospitals is now public information, freely available to anyone with

* It was Dr. Ricardo Rosenkranz of Northwestern University's Feinberg School of Medicine who enunciated that distinction.

Internet access and fingers. Actually, fingers are optional. And it doesn't even matter if what patients report is true.

A few years ago, an elderly woman made an appointment to see one of my partners as a new patient. On the day of her visit, coming up to the office in the elevator, she suffered a cardiac arrest. The people in the building called us to help, so we grabbed our crash cart and ran to the elevator. We worked on her until the ambulance arrived, but to no avail. She passed away. She never even made it into the office for her first appointment.

However, the story that went around town and found its way onto social media was that she had arrested on the way *down* in the elevator, *after* seeing my partner. Unfortunately, that's the kind of story people like to tell.

In this era when information and *mis*information are freely available to all, it's more important than ever that health practitioners strive to give patients the best possible experience. But what does that mean? What do patients want? How do we give it to them and make sure they *know* we're giving it to them?

You'll find the answers in this book.

There are certainly other books about the patient experience, and I'll point you to some of those in Chapter 12, What Others Say. The big difference between some of those books and this one is that I'm not trying to make you a better, more compassionate, more empathic doctor, nurse, or other health practitioner. You already are sufficiently compassionate and empathic. Instead, I'm giving you tools—techniques and strategies—that you can add to your already considerable medical and humanistic skills to give your patients an even better experience than they now get from you.

Think of it this way: Even the greatest athletes in the world still have coaches and trainers to help them stay at the tops of their games. The most successful CEOs have business and leadership coaches to help them in the running of their companies. Even Supreme Court justices have clerks to assist them in staying abreast of relevant laws.

Every one of these people needs to perform at his or her best every single day, and they recognize the need for help to maximize their performances.

Performances. They're all around us every day. We perform many roles ourselves—doctor, spouse, parent—even if we don't realize it. In Chapter 2, we'll examine how we are all performing all the time. If you don't agree with me, let me, for now, leave you with the words of the Bard: "All the world's a stage, And all the men and women merely players… And one man in his time plays many parts."[1] Go argue with him.

If we bring techniques from the stage into the practice of medicine, we can create a better experience for our patients. And who can better show us how to do that than a seasoned performer?

With all modesty, that brings us to me. Sure, for nearly thirty-five years I was an internist and gastroenterologist in one of the busiest multi-specialty internal medicine practices on the North Shore of Long Island; but for fifty years I've been a professional magician and ventriloquist. Guess which I'm prouder of. Actually, that's being a doctor, though the other hasn't hurt—and even helped get me into medical school. Really.

When I interviewed for admission to Columbia University's College of Physicians and Surgeons, the interviewer, the eminent Dr. Andrew G. Frantz*, looked at my application and said, "You say here you're a magician. Do something for me." I was quite taken aback. I'd never been asked to perform at an interview and certainly hadn't prepared anything.

Fortunately, I had a single playing card in my wallet to use for emergencies. A playing card in the wallet is, for magicians, like a condom in the wallet for a teenage boy: You sort of know you're never going to need it, but it's nice to know it's there. I pried the card out of my wallet and made it disappear and then reappear at my fingertips. Dr. Frantz laughed and clapped his hands. "Show me more."

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* He was the first to isolate prolactin.

So I borrowed some quarters from him and made them travel invisibly from hand to hand. He loved it. We concluded the interview on a happy note, and a few weeks later I received my acceptance letter to P&S.

The confluence of magician and physician goes all the way back to their respective origins. Consider this: We know what the oldest profession is, but what's the second oldest? Hunter-gatherer? Nah, everybody did that, so it isn't a profession. Primitive politician? That's a tautology. Neolithic attorney? Nope. Just a variant on the oldest profession.

I strongly suspect that the second oldest profession was healer/magician. Fire up Mr. Peabody's Wayback* time machine and you'll probably find that the first healers were regarded as magicians and vice versa.

So I'm not ashamed to admit that I'm both a physician and a magician, though I usually tried to keep them separate. I was a magician long before I was a physician, and medicine and magic have intertwined themselves throughout my life. And magic has taken me places I never thought I'd go. For instance, to a command performance for tribal elders at a Bedouin wedding in the Negev desert.

A radiologist gave me my first book on magic. For my bar mitzvah, Dr. Myron Melamed and his family gave me *Successful Conjuring for Amateurs* by Norman Hunter. The Melameds knew I had already taught myself ventriloquism and that I had an insatiable curiosity about how things worked, so a book on magic was a natural.

I've read that book more times than I've read *Green Eggs and Ham*, and I have seven kids. *Successful Conjuring* was one so-that's-how-they-do-it revelation after another. I started performing tricks from the book for anyone who would watch—my younger siblings, my parents. The former were an eager audience; the latter were tolerant, mostly.

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* WABAC, for Peabody purists: http://www.toonopedia.com/peabody.htm

The next great influence was our family pediatrician in New Jersey, Dr. Louis Krafchik. He sweetened visits for childhood vaccinations with magic tricks—some fairly sophisticated, as I look back on his performances. I remember thinking, "A doctor who does magic. That's cool!"

As my own interest in medicine and my magic skills grew, I decided I wanted to be a pediatrician, mostly so that I could perform magic for my young patients the way Dr. Krafchik did. Even performing at kids' birthday parties through high school did not dampen this desire. However, taking care of fatally ill children during my pediatrics rotations in medical school did. Hence, I became an internist for adults.

Performing magic, ventriloquism, and hypnosis stood me in good stead in the lean financial years of medical school. I arranged my elective schedule so I'd have easy summers, allowing me to perform in the Catskill Mountains' famous "Borscht Belt" on weekends.

You've paid your performing dues when you start a show at one o'clock in the morning for an audience that has just returned from a losing night at nearby Monticello Raceway. Or when you introduce yourself to the entertainment director, who says, "Hypnotist?? We were told we were having a stripper!" I did my hypnosis show fully clothed anyway.

I continued to perform magic and mentalism through my fellowship years and then for fundraisers and private events once I went into practice. I also performed ventriloquism for friends, family, and private groups I belonged to until 2008, when I asked myself if I was good enough to entertain people who didn't know me and wouldn't be rooting for me. I took a course in stand-up comedy at a local comedy club and began performing in clubs on Long Island and in New York City as well as at numerous private parties, fundraisers, and church and synagogue shows.

In 2013, my ventriloquism mentor, the legendary (among show people) Sammy King, suggested that I audition for the NBC television

show *America's Got Talent*. I decided to perform with my talking large intestine puppet, Sigmoid Colon. Hey, I'm a gastroenterologist, okay?

However, before my audition for the "celebrity judges," I was informed that the producers had learned that one of the judges, Howard Stern, was my patient.* They told me they saw a conflict of interest and that, no matter how well I did, they were not going to let me advance to the next round.

That was okay. I had a good day job and I got to perform ventriloquism on TV in prime time for eleven million people. You can watch my audition on YouTube†, but know that the producers actually changed two of the judges' votes to assure that I would not progress to the next round. You can read what *really* happened on *AGT* in the somewhat self-indulgent Appendix IV.

Back to the patient experience and this book. I've strived to make the book practical, to the point, and, because I like entertaining people, enjoyable to read for the practitioner who already has too much to read and too little time to do it. To accomplish these goals, I've limited the book's scope and thrown in a few jokes.

"Patient experience" and "patient satisfaction" encompass a very big universe involving health systems, administrators, CEOs, employees, institutes, researchers, etc. Those terms incorporate what happens to patients in hospitals, what the government wants hospitals to do, how patient experience should be measured and reimbursed, and on and on. None of that macrocosm is the purview of this book. I have concentrated on the one aspect of the patient experience *we* can control—the precious few minutes we have in direct face-to-face contact with the patient.

Unlike some other books on the subject, my goal is not to make you a better doctor. I don't want to completely change how you communicate with patients, but rather to give you some simple tools to do so more

* No HIPAA violation here. He's told his twelve million listeners that I was his doctor, so I can tell you.

† https://www.youtube.com/watch?v=9nP7gpou9qs

effectively. I'll offer you some easily implemented techniques and strategies that will improve the patient experience and the ratings your patients give you.

Now, you might accuse me of "teaching to the test," of just suggesting superficial things to make patients happier and get you better ratings. Nothing—well, few things—could be further from the truth. You see, I already believe that you're a caring, empathic person. It's part of why you became a caregiver. So I want to give you practical ideas to supplement the strengths you already have, not ask you to develop new ones.

By putting these techniques and strategies into practice, not only will your patients have a better experience, but you will too. You'll enjoy practicing more. As we'll discuss in Chapter 2, a good performance benefits the audience *and* the performer.

My approach to the patient experience is one I've developed from nearly thirty-five years of private practice and fifty years of performing onstage and has garnered me excellent Press Ganey scores and online reviews. I'll offer many ideas from which you can choose those that appeal to you. They are all easily implemented without making huge changes in your staff, your practice, or yourself. And, very importantly, they don't take any more of your precious time.

★ ★ ★

It took me about forty-four years and ten months to write this book.

That's four years of medical school, three of internal medicine residency, two of GI fellowship and then almost thirty-five of medical practice. Those years comprise over a hundred thousand patient visits, every one of them unique. I also performed about twenty thousand endoscopic procedures, not so unique since a lot of stomachs and colons look pretty much the same. There were countless routine physicals, URIs, UTIs, irritable bowels and refluxing esophagi, serious and fatal illnesses, weird infections, stress-related illnesses, easy cases,

head-scratchers, triumphant diagnoses, social issues, family tragedies, and three mistakes that haunt me to this day.

Then came the ten months of researching, writing, editing, and rewriting to actually get it all into a book. What I included I learned from my many years of practice, from a review of the literature, and also from interviewing superior physicians with excellent patient ratings. They let me pick their brains and ask them what specific things they did to satisfy their patients.

One such interview stands out in my memory. I talked with an experienced and much-beloved internist who is consistently one of the highest-rated physicians in our area. I asked, "What's your secret?"

"I give every patient a thirty-minute visit."

"Come again?"

"Yes, every routine appointment in my office is thirty minutes, except yearly physicals; they're an hour."

"Wait a minute," I interrupted. "What about routine blood pressure checks?"

"Thirty minutes."

"Viral URIs?"

"They get half an hour," he sort-of joked.

"Those things don't require thirty minutes to take care of. What do you do the rest of the time?"

"I schmooze with them."

If your practice runs that way, please put this book down and get your money back. I have nothing to teach you. But if you're harried, think you don't have the time to serve your patients the way you'd like, are not getting the ratings you believe you deserve, and are not enjoying practicing medicine as you should be and want to be, keep reading. This book is for you.

If you've had a hospital or practice administrator come to you and say, "Your patient satisfaction scores are not high enough, and you need to improve them starting right now," this book is for you.

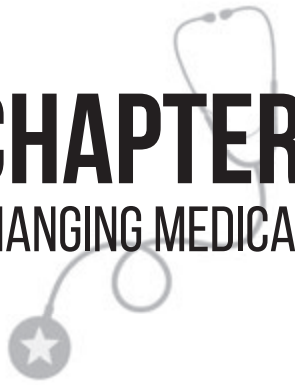
If you have made the mistake of going online to see what your patients had to say about you on Yelp! or Angie's List, or HealthGrades, or RateMDs and you didn't like what you saw, this book is for you.

If you want to preserve your income, this book is for you.

If there are days you dread going to work, this book is for you.

But most of all, if you are already an excellent practitioner—a doctor, nurse, nurse practitioner, physician's assistant, etc.—with great bedside manner who is always looking for ways to give your patients a better experience and who wants to enjoy practicing more…

This book was written for you.



CHAPTER 1
THE CHANGING MEDICAL WORLD

Sometime after midnight on a frigid winter night near Chicago in the late 1950s, an eight-year-old boy was crying quietly in bed, having been awakened by the pain in his right ear. He knew what it was: yet another ear infection. His mother tried to lower his fever by giving him St. Joseph's Aspirin for Children and sponging his shivering body with diluted rubbing alcohol. She did what she could pending a house call by the family pediatrician, Dr. Elmer Kadison.

Dr. Kadison soon arrived in an overcoat thrown on over his pajamas and bathrobe. The boy's parents later expressed admiration that Dr. Kadison had rushed to their son's bedside without even bothering to get dressed. The doctor seemed not the least put out about coming out in the middle of the night to see yet another sick kid.

He examined the boy carefully and gently, not gagging him with the tongue depressor nor shoving the otoscope too far into his ears, all the while talking to him in a soft voice. From his magical black bag of instruments and cures Dr. Kadison gave the boy a "sucker" to soothe his throat and the parents a bottle of Aureomycin to cure his otitis. The boy felt gratitude and relief and thought, "I want to be like him."

That's why I became a doctor.

Many colleagues have told me similar origin stories of how they were influenced by physicians to become doctors themselves, of how a deep-

seated desire to help other people meshed perfectly with a fascination with the biologic sciences or being skilled with their hands or both. How the need to help people, to fix them, to comfort them, drove the proto-physicians to become super-achievers and eventually doctors. And damned good doctors, at that. So why is it that the satisfaction of being a doctor is ebbing? Maybe it's because it seems that everything about medical practice is changing—and not for the better.

The very doctor visit itself has changed. For generations of physicians, while medicine itself evolved constantly, the practice of medicine remained comfortingly steadfast. Aside from the disappearance of the house call, which was once the most common way physicians saw patients ["Jimmy, run get Doc Wilson! Tell him the baby's a-comin'!"], the routine of how patients saw their physicians was unvarying. The patient rode her horse or, for the last century, drove his car to the doctor's office, sat in the waiting room while avoiding eye and germ contact with other ill people, and eventually went into the consultation/examining room for the face-to-face with the physician. The doctor smiled, chatted a bit, and then asked questions, took inscrutable notes on paper, examined the patient, ruminated, and finally wrote something even less scrutable on a prescription pad. The patient left the doctor, paid the bill with the receptionist, and went off to fill the prescription with the friendly local pharmacist.

Today, everything—except the horse—is the same until you walk into the exam room. Then you are pressed for time. Maybe your employer only allows for a seven-and-a-half-minute office visit. A computer stands interposed between you and the patient. The exam may be more perfunctory. You e-scribe a prescription to the big-box pharmacy-cum-grocery-cum-hardware store that contracts with the patient's insurance plan—if he's lucky enough to have one. The patient leaves a co-pay at the desk or pays in full if he has no insurance plan. And a few weeks later he receives a survey in the mail about his experience with you.

Is that what you thought you were getting into when you became a doctor? Is that how you envisioned your day-to-day life when you dreamed of one day taking care of people?

I think not.

WHAT'S GONE WRONG FOR US

Once upon a time, being a good physician was enough to virtually guarantee a successful career. In the antediluvian 1980s, when I first went into practice, all one had to do was follow the tenet, often attributed to Sir William Osler, of a new physician's three crucial *A's*: *availability*, *affability*, and *ability*, in that order. In my new practice, I had plenty of open appointments, lots of time to be nice, and a head full of medical knowledge. My practice grew and thrived. By the time I retired, at age sixty-five, I had long since stopped taking on new patients. There were simply not enough hours in the day nor sufficient ATP in the mitochondria to serve everyone who wanted to see me.*

Today we need to add a fourth *A*, *adaptability*, because the practice of medicine is undergoing the most radical changes we've seen in our lifetimes:

- Fifteen years ago, 75 percent of American physicians were in private practice and 25 percent were employed by hospitals, health systems like Kaiser Permanente, or the government. Today the percentages are reversed. We've gone from being our own bosses to being cogs in the large, impersonal healthcare machine.
- Electronic health records, supposedly a boon to the practice of medicine, have turned out to be a boon to billers and regulators, but a boondoggle to physicians struggling to record cogent

* Osler also said: *My second fixed idea is the uselessness of men above sixty years of age, and the incalculable benefit it would be in commercial, political, and in professional life, if as a matter of course, men stopped work at this age.* I am so done with him.

and succinct histories, physicals, and treatment plans for their patients.
- Patients are rating physicians on the Internet and choosing doctors based on online reviews.
- For more than a century, the model for physician reimbursement was simply fee-for-service: An office visit cost $X. Electrocardiogram, an additional $Y. Lab work, add on $Z. Surgery or procedure, $25Xn. Within a few years, however, fee-for-service will be gone, to be replaced with I-don't-know-what-and-they-don't-know-what-exactly.

But what *is* known is that what our patients think of us will play a crucial role in whatever the new payment models will be. However our compensation is determined, our patients' satisfaction with their visits with us will be one of the linchpins of our survival. And our survival will depend on our *adaptability*.

WHERE DO WE GO FROM HERE?

For many doctors, particularly those who have been in practice for several years, the future looks discouraging. We face a loss of income, a loss of autonomy, a loss of respect.

For instance, when I joined my practice in 1982, we doctors set the fees we charged. The patients paid at the exit window for the services rendered and received a form to submit to their insurance companies for reimbursement. I once overheard a patient complaining to the senior partner of the practice that insurance would not reimburse the full amount for the visit. I cringed when I heard my partner bluntly reply, "It's your insurance, not mine." But in those days, he was right. With exceptions for people who were financially strapped, our fees were our fees, and that was that.

Now the insurance companies set our fees based on some formula only they know. No discussion, no negotiation. Accept our fees or

say goodbye to all your patients that we insure. I realized how bad our insurance reimbursements had become when I discovered that traditionally stingy Medicare had become my highest payer. Since the insurance plans' fees were lower than what we'd previously charged, our incomes dropped.

We physicians have also lost much of our autonomy. In making medical decisions, there was once one principal factor to consider: What was best for the patient. Period. Then, when malpractice suits became increasingly common, we had to start ordering additional tests to protect ourselves from the lawyers and, sadly, from our patients. So we started practicing CYA defensive medicine. And now insurance company functionaries are often the final arbiters of our medical decisions, with ultimate control over what tests we may order and what medications we may prescribe.

Regarding respect, there's an interesting dichotomy between reality and perception. A Harris Poll survey in 2015 found "physician" to be the most respected occupation in the country, with 90 percent of Americans considering doctoring to be a prestigious profession.[1] (This put us ahead of scientists and police officers and way ahead of PR consultants, who placed dead last.) While 90 percent of Americans *would* recommend medicine as a career for their children, 90 percent of physicians *would not*.[2] One of the most common reasons cited by doctors was the feeling that the profession was losing respect.

In a 2011 Consumer Reports study, 70 percent of primary care physicians believed that "since they had started practicing medicine, respect and appreciation from patients had gotten 'a little' or 'much' worse."[3] Doctors regularly complain online about how lack of respect from patients, insurers, and even hospitals makes their jobs harder.[4] One doctor even wrote a powerful memoir about the descent of the profession's image "from knighthood to knavery."[5]

So now what? It's too late to turn back. You're a physician or a surgeon, and short of getting an MBA or going to—heaven forfend!—law school, doctoring is what you are going to do. Until golf sets in.

After all, you've invested nearly half your life becoming a doctor. When you finished your residency or fellowship, you were graduating from between twenty-third and thirtieth grade. Then, and only then, could you start to earn a living while paying off debts. But you knew that you would have a truly fulfilling career and would do a world of good for other people along the way. For many of us, though, it seems as if the personal satisfaction of practicing medicine is slipping away—or, more accurately, being taken from us.

Our profession has become relegated to a position somewhat less than noble. Yes, we are still trusted by the public, ranking third behind only nurses and pharmacists. (And well above lawyers, HMO managers, and members of Congress, I might add.) However, most of us are now employees of hospitals, health systems, HMOs, or Accountable Care Organizations. This renders us interchangeable and, worse, makes us have to answer to people other than our patients. To put it bluntly, we have lost our special place in society's eyes—and in our own eyes.

WE ARE IN THIS TOGETHER

On the old stone entrance to Columbia Presbyterian Medical Center on 168th Street in New York City is carved the biblical inscription *For of the Most High Cometh Healing*. As a medical student at Columbia P&S, seeing those words as I walked to class every day reminded me that I was pursuing not just a job, nor even a career, but a higher calling. The long hours of sometimes tedious study (Do I *really* have to remember the peregrinations of the fifth cranial nerve?) were leading me to fulfill a childhood dream of being a doctor.

For several years that dream was fully realized. I built a thriving private practice with partners I liked and admired. I developed friendships with patients that lasted decades; they called me Dr. Bob. I had families for whom I took care of four generations. I made a good, if not spectacular, living. Then everything started to go downhill.

In the early to mid-1990s my practice, like many of yours, was shaken to the core by "managed care." After the failure of the Bill and Hillary healthcare reform initiative, the insurance companies took over healthcare. Suddenly, some of my long-term patients couldn't see me because their employers had changed insurance plans, and I wasn't on their new panel of "primary care providers." I could not always refer to specialists I knew well and had used for years because they weren't on the same panels as I. And even if they were, I had to get some functionary's permission for a specialist referral. I had been relegated to the role of "gatekeeper." Not what I had dreamed of.

One day I was complaining so much about what was happening in medicine that my fifteen-year-old daughter casually informed me, "Daddy, you have a crappy job." Her precocious perspicacity might explain why today she is a highly-paid business consultant.

Over time, insurance companies became the de facto overlords of medicine. They set fees—my small seven-doctor practice was in no position to bargain with them. The insurance companies required us to get pre-authorizations on routine tests such as CT scans, so we had to add a full-time employee just to get permission to order the tests. The overlords struck deals with pharmaceutical companies to reduce the costs of medications and thus restricted the formularies of medications we could prescribe. We needed to hire another full-time person to work on medication refills and authorizations.

When my prescription maven was unable to get approval for a medication, I had to get on the phone to advocate for my patients and argue with the insurance company representative.

My editor made me remove the several choice epithets I'd written about the people who formulated the policy that led to the following incident:

A young patient of mine, Alex, fresh out of law school, got a new job which provided healthcare insurance (lucky him!) with a different insurance company than he'd had when he was on his parents' plan.

Alex was very bright and personable, but when he was in college he had started having great difficulties with his studies. He underwent neuropsychological testing and was found to have ADHD. The psychologist recommended Vyvanse, which my patient's pediatrician prescribed. Alex's response was excellent. He completed college and law school, passed the bar exam, and joined a prestigious firm in New York City. By then he had outgrown the pediatrician and had been my patient for a year.

However, when Alex went to his pharmacy to pick up a refill of his Vyvanse, he was told that the medication was not covered by his new insurance company. The pharmacist told him that he had to try other medications first.

I put Marie, my prescription maven, on the case, and she promptly hit a brick wall. The insurance company representative told her that Alex would have to *try and fail on* three other medications before they would approve the Vyvanse. I got on the phone and got no further with the representative than Marie had.

So I asked for the supervisor and got no further with her. Finally, after days of phone calls, I reached the company's medical director. Initially he reiterated the policy to me. I said, "If you make this man try three other medications, suppose they don't work? By your rules, he's going to have to try one after the other until *maybe* he finds one that helps his condition. But while the medications are failing, his career could fall apart." Fortunately, the medical director saw the merit in this argument and approved the Vyvanse—for a year.

And with another patient, this conversation really happened. Really.

Me: *Hello, this is Dr. Baker. Who is this, please?*
Jones: *This is Mr. Jones from the formulary department. How can I help you?*
Me: *Thank you, Mr. Jones, for taking the call. I'm calling about my patient Mrs. Jean Connolly…*
Jones: *Cannoli?*

Me: *No, Mrs. Connolly. I recently started her on 100 mg of a new diabetes medication, but it wasn't controlling her sugar well enough, so I raised the dose to two 100 mg tablets a day, but her plan wouldn't cover that.*
Jones: *That's right. We cover one 100 mg tablet.*
Me: *But she needs 200 mg.*
Jones: *We don't cover two 100 mg tablets a day.*
Me: *But in my medical judgment that's what she needs. [That should do it, right?]*
Jones: *There is a 300 mg tablet. We do cover that.*
Me: *I understand, but I'm concerned that 300 mg might make her hypoglycemic.*
Jones: *Then prescribe the 100 mg.*
Me: *I did that, but it wasn't enough. I want her to try 200 mg.*
Jones: *We don't cover that.*
Me: *I know you don't cover that, but that's what the patient needs.*
Jones: *100 mg or 300 mg, doctor, that's what we cover.*
Me: *I understand that, but I've known her for fifteen years, and I think…*
Jones: *Is there anything else I can help you with today, doctor?*
Me: *[unprintable]*

Yeah, that's why I went to school for all those years and missed all the fun my friends were having. So I could do *that*.

As the pressures on our practice grew, we decided to merge with the local hospital, which has since grown into a major health system. When I retired, I had gone from being one of seven internists in an intimate practice to one of two thousand physician employees. After I left, a new doctor was brought into the practice to take my place.

REVIEWS? WE DON'T NEED NO STINKIN' REVIEWS!

Word-of-mouth built my practice. But now we're all subject to word-of-net. A study published in *Medical Economics*[6] showed that 77 percent of patients will look at online reviews when selecting a new

physician. If you've never looked yourself up on the Internet (in which case you're smarter than I), go check your ratings on HealthGrades.com, or Yelp!, Angie's List, RateMDs.com, vitals.com, or CareDash.com, to name a few. You may be pleasantly—or unpleasantly—surprised. Probably some of both. Go ahead and look. I'll wait right here for you.

Recovered? Try a few deep breaths. It can help.

Most patient online reviews around the country are positive. In 2013, Vanguard Communications studied ratings of over forty-three thousand providers in the one hundred largest US cities. About 57 percent of the doctors received four stars or better.[7]

Nevertheless, the problems with online review sites are legion.[8] The greatest is that reviews are statistically insignificant—wildly so. The second biggest problem is that potential patients don't know that and believe that such reviews accurately reflect reality. Look, if two of three people who've posted reviews give you five out of five stars and one angry person gives you one star, you average out to three and two-thirds stars. So anyone online scanning a list of doctors in their area is going to find you way down below all the four- and five-star doctors—if they even bother to plunge that far into the depths of the list.

This exact scenario happened to me. On one site, I had two lovely reviews and one from a patient who wrote three paragraphs hating on my office. She had waited a long time for an appointment for a shingles shot only to find out on her arrival at the office that we had run out of vaccine. Unfortunately, no one had called her to reschedule her appointment, and she was angry, which I completely understand. But the one-star rating she gave me dragged me down near the bottom of the list of doctors in my area.

One infrequently cited problem with online reviews is that they can undermine current patients' confidence in us. Don't we sometimes look up restaurants we frequent or cars we drive to see the reviews? What do our patients think if they see we have less than stellar ratings? Maybe a low score eats into their confidence in us. It can even chip away at our confidence in our colleagues.

I once had a patient complain to me that he had looked up a neurologist I had referred him to before making an appointment with the doctor. "How could you send me to that guy?" he asked. "Have you seen his reviews?" I hadn't. Why would I look up the reviews of someone I knew to be an excellent practitioner?

I wanted to say, "Whom are you going to believe, me—your doctor—or your lying eyes?" Instead, I explained that I had been sending patients to the neurologist for twenty years and had never had a complaint from a patient. The denouement? My patient did not see that neurologist. Nor did he see me ever again.

There's plenty of advice available about how to deal with negative online reviews.* For instance, the health system I worked for gave doctors a chance to challenge critical patient comments before posting them on our profiles on the system's website. There are businesses that help doctors manage their online reputations.[9] What concerns me more, however, is how to prevent bad reviews in the first place, how to deliver such an excellent patient experience that no one would think of giving you a less than five-star review. That's what this book is about.

As if online reviews from patients weren't enough to worry about, consider this: It's not just the patients who are looking at our reviews. The payers are, too. The Centers for Medicare and Medicaid Services (CMS), Kaiser, the Blues, and United Health Care all have pilot programs examining using patient satisfaction scores to help determine physician compensation.

As I mentioned before, fee-for-service is going away. Someone realized that if you reward practitioners for doing more, they'll do more—not necessarily more than is needed, but certainly more. Now those same someones have decided that this current mode of physician reimbursement is unsustainable. In casting about for other payment models, they've decided that it's better to reward quality than quantity. So they've come up with "quality measures," which CMS defines as

* I especially like *Hug Your Haters* by Jay Baer. New York: Portfolio/Penguin, 2016.

"tools that help us measure or quantify healthcare processes, outcomes, *patient perceptions* [emphasis added], and organizational structure and/or systems that are associated with the ability to provide high-quality health care…"

We are being bombarded by a torrent of acronyms—MACRA, MDP, EMA, QCDR, MIPS, APMs, ACOs, PFPMs—which may or may not be in place a few years from now. And those are just from CMS. Who knows what future pleasures the insurance companies have planned for us?

Therefore, I'm going to ignore all that *chazerai*. For our purposes, I'm going to assume, as I noted earlier, that you are an excellent clinician, and that your "healthcare processes and outcomes" are already excellent. In fact, you probably assume that, too, since studies show that two-thirds of us physicians consider ourselves to be better than average doctors.

Instead, let's concentrate on the "patient perception" piece. Now it's uncertain how much of our reimbursement will eventually be based on patient satisfaction scores, but according to Francois de Brantes, executive director of the Health Care Incentives Improvement Institute, it should be as much as "a solid third."[10] And that approximately 30 percent does not exist in isolation, since studies show that improved patient satisfaction leads to improved patient compliance,[11] which, of course, affects that other 70 percent—the quality measures.

As we'd expect, physicians are not happy with the prospect of patient surveys affecting their salaries.[12] Why would we want to change a system that has rewarded us well for decades? Moreover, surveys could be subject to bias, manipulation, and averaging,[*] to say nothing of patient spite.

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[*] For instance, when I looked myself up on Medicare's "Physician Compare" website, I was stunned by my poor performance scores. One example: I'm an internist/gastroenterologist, and my colorectal screening score was reported at an abysmal 67 percent. Then I saw that Medicare was actually reporting the results of the two thousand physicians in multiple specialties (including psychiatrists and orthopedists) who work for my employer. I was lumped in with everybody, so I'm guessing those orthopedists pulled my colon-cancer-screening score down.

Yeah, well, too bad, doctors. The new reimbursement model is happening,[13] so we need to figure out what we can do to improve our personal patient satisfaction scores. The good news is, it's easy to do consistently and ethically. And, as you'll see, with greater *physician* satisfaction scores.

What we need is a path back to those emotions that made us want to become doctors in the first place, a way to experience them every day at work, no matter how stressful our day or what outside forces conspire to make us unhappy. We need to rekindle our love of our profession, to reignite the passion that made us devote half our lives to becoming physicians.

Think of your own origin story; I'm sure you have one. Somewhere inside the tired, beleaguered, discouraged, current-day you is the young woman or man who dreamed of being a doctor, who sacrificed seemingly endlessly to become one of the select group of people who are privileged to take care of other people, to join the ranks of those from whom "cometh healing."

Despite all the pressures we face, there is a way to enjoy practicing medicine every day, and to have the personal satisfaction that being a doctor should bring. There is. That is to focus on the only aspect of patient experience that we can control—our direct face-to-face encounters with our patients. We do that by performing our best when we see patients.

TAKEAWAYS

- The practice of medicine is undergoing the most radical changes of our lifetimes.
- Doctors face a loss of income, autonomy, and respect.
- Many physicians are unhappy with their choice of profession.
- As fee-for-service vanishes, quality and patient experience will come to the fore.
- The only thing we can directly control is the patient encounter.

CHAPTER 2
THE PATIENT VISIT IS A PERFORMANCE

Lissencephaly. Do you remember what it is? I didn't. I was far enough removed from medical school lectures on disorders of fetal neuronal migration that, when my new patient, Mrs. Enescu,* told me that her three-year-old daughter had it, I had to nod sagely and then dash to my office and look it up while Mrs. E. was changing into a gown for her exam.

The word lissencephaly comes from the Greek for "smooth brain" because the cerebral cortex develops in utero with either small (pachygyria) or no (agyria) gyri, the brain surface's folds and convolutions. Children with this disorder have a variety of disorders of variable severity, including psychomotor delay, seizures, feeding and swallowing difficulties, and respiratory abnormalities from frequent aspiration. Prognosis is poor.

Mrs. Enescu's daughter, Sarah, has agyria and lives at home on a respirator with twenty-four-hour nursing care provided by her mother because insurance won't cover… well, that's another issue. Mrs. Enescu gave up a high-powered corporate job in New York City to tend to her daughter. Mr. Enescu is a scientist at a physics laboratory which is generous in the time it allows him to work from home to relieve his wife.

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* Not her real name, of course.

Sarah herself has a small head with lots of curly hair, sparkling eyes, and a sweet, sweet smile. She sits propped up in her hospital bed with a favorite stuffed mouse as her constant companion. I know because her mom always brings pictures to show me. In the photos, Mrs. E. had arranged Sarah's clothes to hide her tracheostomy and jejunostomy tubes. The photos don't show that now five-year-old Sarah functions at the level of an infant.

Mrs. Enescu is unremittingly positive and upbeat about Sarah. I understand this, as I am the father of two children on the autism spectrum. Positivity and hope for our children is what gets us through each day. However, my children have a normal life expectancy. Sarah's does not extend much beyond ten years.

One day, after she'd been my patient for a few years, Mrs. Enescu came in for a routine blood pressure check. As I always did, I started our visit asking about Sarah, and her face fell.

"Oh, Dr. Baker, it's terrible," she said. "Sarah just spent three weeks in the pediatric ICU with uncontrollable seizures. The doctors tried all sorts of different medications, but before they found the right combination, her feeding tube fell out, and she developed pneumonia. She almost died, but finally they let us bring her home.

"We know it is for the last time."

Suddenly, Mrs. Enescu's blood pressure was not the main focus of her visit. I felt a flood of sadness and loss fill me to my brimming eyes. We hugged. We cried. We looked at pictures. I supported her as best I could.

And eventually I checked her blood pressure.

But then I was twenty-five minutes late for my next patient, who was a nice, middle-aged lady coming in for a routine physical. I didn't know how I was going to get through it. I felt emotionally, even physically, drained.

So I gathered myself, stood outside the exam room door, put my hand on the knob, and heard myself say under my breath, "Robert, it's showtime." I stood up straight so I'd have energy, put on my warmest,

friendliest smile so I'd feel good, opened that door, and performed a really good, empathic history and physical. And for the rest of the day, I felt much better. I had performed well for my patient.

PERFORM THE RITUAL

That episode coalesced, for me, an idea I'd had for a long time: that when a doctor sees a patient at the bedside, or in a consulting office, or in an exam room, it's a performance. That's right, a performance.

When I've propounded this idea to doctors, some nod in agreement, but many seem scandalized, or at least annoyed at my effrontery. After all, isn't a doctor the *opposite* of a performer? A doctor is a clinician, a scientist. A doctor is genuine, caring, and empathic—certainly not a performer, certainly not a *fake*!

However, my contention that the doctor visit is a performance makes a lot of sense with a definition of *performance* that takes it out of the show business context. According to Erving Goffman, considered by many to be the most influential American sociologist of the twentieth century, a *"performance" may be defined as all the activity of a given participant on a given occasion which serves to influence in some way any of the other participants.*[1] And then there's what Shakespeare said about the world being a stage.

I started to formulate this idea of the patient encounter being a performance very early in my practice thanks to one of my senior partners, Dr. Michael Cohen, an eminent and immensely popular physician in our community. You see, when I first went into practice, I had no idea what to expect. I had trained in the academic centers of Columbia, Cornell, and Harvard and so had a very skewed idea of the spectrum of human illness.

For instance, from my GI fellowship at Beth Israel Medical Center in Boston, I had concluded that the most common gastrointestinal ailments in the population were inflammatory bowel disease, primary biliary cholangitis, Laennec's cirrhosis, and major gastrointestinal

bleeding of various etiologies. Oh, and the occasional infectious diarrhea.

So imagine my surprise when I ended up in private practice in the Long Island suburbs of New York City and saw only inflammatory bowel disease from the above list. I did see lots of gastrointestinal reflux, dyspepsia, and irritable bowel syndrome. Where the hell did they come from?

I was so distressed that after a month I called my mentor at Beth Israel, Dr. Mark Peppercorn, to complain about the narrow spectrum of diseases I was seeing. He laughed and said, "That's what outpatient GI is!" Oh.

To add to the July of my discontent, I was also doing general internal medicine, something no self-respecting, academically trained, third-year GI fellow would be caught dead doing today. So besides the folks with belching, heartburn, and constipation, I was also seeing kvetchy people with upper respiratory infections and raging fevers of 99.3 ("I usually run below normal."). My patients were quick to educate me that this medical situation required a Z-Pak. Phoned in now!

After I'd been in my new practice for a few months, my partner Michael came into my consulting office to tell me that he was receiving complaints about me from his patients who had been stuck seeing me when he was already booked. They were telling him that I wasn't taking their complaints seriously enough.

He suggested that I take a more thorough history and perform a more detailed physical examination. He showed me how to use a special light we had for transilluminating sinuses to look for opacification in patients with URI symptoms. Dr. Cohen also suggested I show the patients some *rachmones*, Yiddish for compassion.

At first, this really annoyed me. I said, "Are you kidding me? You want me to treat a head cold like a serious medical problem?"

He gently responded, "If they're taking time out of their days to see you, for them it *is* serious." Michael reminded me that the patients

might be concerned that their symptoms represented something more threatening than just a cold, or that they might just have wanted my assistance to feel better and return to their normal lives. Okay, I got that.

But then he said something that initiated the change in how I thought about the patient encounter. He pointed out that the doctor visit is a kind of ritual involving an authority figure wearing a costume (white coat), the telling of a story, and the laying on of hands. Supplicants even receive an amulet in the form of a prescription. He added, "Patients expect that we will perform the ritual in its entirety and seriously and they won't be satisfied if we don't."

"Perform the ritual." The words resonated with me. "Perform the ritual." Then I had a junior-associate flash of intuition. The ritual is a vital part of the healing process. How else to explain what I bet you've heard many times from patients departing from a visit: "You know, doc, I feel better already!"

It's wonderful, right? Because we haven't done anything, except *perform the ritual*. And patients expect that we will perform it. It was then that I realized that, when a doctor sees a patient in the exam room, or at the bedside, or in the consulting office, it is a *performance*. And, as we'll see, a good performance produces a better result for both doctor and patient.

But first, we'd better address the issue of performances being somehow fake or inauthentic. Such an assumption presumes that the performance is superimposed on, and not part of, the performer's genuine thoughts or feelings.

Michael Port, the author of the seminal *Steal the Show*,[2] succinctly addresses this notion in a single sentence:

Good performance is authentic behavior
in a manufactured environment.

Please read that again, and we'll break it down.

By "manufactured environment," Port means a situation which is created for a specific purpose. He's a trained actor, so for him a manufactured environment might be a stage or a movie set. When we see two characters in a movie talking in their home's living room, that living room is merely a set designed to simulate a living room—a manufactured environment. But a lawyer speaking in a courtroom is also in a manufactured environment. It's real life, but the setup is created as a place for the law to come to life.

For us, calling a doctor's visit a manufactured environment might seem a stretch. After all, it's what we do every day, so nothing seems "manufactured." But for the patient, everything is. First, they have to drive to a place created for the purpose of doctoring. Then they have to answer questions about very personal things. Finally, they must undress to have their bodies poked and prodded by a near-stranger. It's totally outside their everyday experience.

And then, Michael Port says that in good performance behavior is authentic. How do actors make a performance authentic? They do it by committing to the characters they are playing and to the reality of the situations the characters find themselves in. They also do it by showing themselves to be human and vulnerable.[3]

This is exactly what we need to do as physicians to establish rapport with our patients and to get maximum therapeutic benefit from the visit. We need to act authentically and be fully committed to the situation. We also need to let our humanity and vulnerability show.

Now, you might be thinking, "I'm not an actor." Well, neither am I. But I know you have performing experience. Perhaps you appeared in your fifth-grade elementary school play. You may or may not have been stellar, but it was a performance. Maybe you've offered a toast at a wedding. You had to get up in front of a group of people, many of them strangers, and give a speech that was humorous and meaningful to the bride and groom. Perhaps you've given a speech honoring a retiring colleague. Both were performances.

When you interviewed for college or medical school or even your current job, you had to present the best version of yourself to the interviewer. You had to be your best you. In those interviews, your behavior was authentically you; but still, those were performances.

Or how about the time one of your kids used that perfectly placed curse word? It was hilarious, right? But you couldn't laugh (unless you're a lousy parent like me). You had to play the role of stern and disapproving parent. You put on a performance.

If you stop and think about it, life is full of authentic performances. When a lawyer summarizes a case before a jury, that's a performance.* When an airline pilot comes on the intercom to give a reassuring preflight announcement, she is playing the role of her best pilot self. It's authentic, but it's a performance. When an expert waiter gives excellent service at a restaurant, he's bringing his skills and knowledge to provide a wonderful dining experience. That's a performance.

Great performances involve the audience and produce genuine emotions in them. And we want to produce emotions in our patients because, to paraphrase a quotation attributed to Maya Angelou, our patients will forget what we said, and they'll forget what we did, but they'll never forget how we made them feel.†

Now, what about every time you see a patient at the bedside or in an exam room or in your consulting office? If you look carefully at yourself in those situations, I'm guessing that you can see elements of your behavior, language, personality, mannerisms, and even physicality that aren't a part of your life anywhere else. I submit that what you are doing there *is* a performance. You've been doing it for years, but probably not consciously. This book aims to raise your performance from unconscious to purposeful to five-star patient experience.

And there's no fakery involved, because the part you are playing is yourself. Not your hassled, worried-about-the-mortgage,

* Okay, maybe I shouldn't use that as an appealing example for doctors.

† She was herself paraphrasing an earlier quotation from Carl Buehner: "They may forget what you said — but they will never forget how you made them feel."

running-behind-schedule self. Rather, you are playing your physician self. This is different from your parent self, or your soccer coach self, or your going-out-to-eat-with-friends self. Each of these, including your doctor self, is an integral part of you.

To repeat the wisdom of Shakespeare in *As You Like It,* "All the world's a stage, And all the men and women merely players… And one man in his time plays many parts."[4]

Sixty years ago, Erving Goffman analyzed this idea further in his seminal work *The Presentation of Self in Everyday Life,* in which he demonstrated how we show the world different aspects of ourselves depending on the circumstances we are in.[5] In addition, he showed that our performances are an expression of our own identities.

We'll learn more from Goffman later, but what I'm asking you to do in this book is to consider every patient encounter to be a performance, one that is an authentic expression of your true self. I'll show you the skills, techniques, and strategies that will enable you to make every patient interaction a stellar performance.

WHY SHOULD I BOTHER?

You probably pride yourself on your bedside manner. Especially if you've been doctoring for a number of years and have a successful practice, you're confident you have that part nailed down. And you may feel that you don't need some gastroenterologist/ventriloquist telling you how to behave with your patients. Well, as Dr. James Merlino, the chief experience officer of the Cleveland Clinic, puts it, "There's an important, significant disconnect between how we as providers think we communicate with patients and how patients rate our ability to communicate… If you ask physicians to rate themselves on patient communication, they'll say they are excellent and that they have excellent patient relationships."[6]

I'd add that even the greatest tennis player of all time, Roger Federer, has a coach. Mariano Rivera, the greatest relief pitcher of all

time, worked every day with a pitching coach. Every little bit that they upped their games helped their performances. Furthermore, treating every patient encounter as a performance has benefits for both you and your patients.

It starts the process of healing.

I believe in my heart that the magic of healing begins when a doctor and patient sit down together and start to talk. Everything else we bring to the encounter—our technical prowess, our smarts, our fund of knowledge—is of little use if we don't understand the patient's medical issues and concerns and if we don't communicate that understanding to him or her.

As I said in the Introduction, the goal of any performance is to *connect with* and *communicate with* an audience, in this case your patient. By employing the skills and techniques that great performers use, we can greatly enhance that communication, make that connection, win the patient's trust, and give him faith in our competence and dedication to his care.

It helps you to focus on the patient.

The distractions of daily medical practice are many: the seemingly unending stream of telephone calls from patients, requests for refills, drug company reps who want to bribe you with lunch, interruptions by staff, forms waiting to be filled out, knowledge that the next patient is waiting, perhaps for too long, and on and on.

Now, some people believe that they can multitask. Research indicates, however, that our perceptions of our ability to do several things or think and deal with several problems simultaneously are "badly inflated" with "little grounding in reality."[7] For instance, we may think that we can drive and talk on the phone simultaneously, but research shows that doing so impairs our driving to the same degree as ethanol intoxication.[8]

Dr. Theo Tsaousides, the author of *Brain Blocks*, puts it this way: "While your brain can handle multiple things at once in the background

[controlling breathing, regulating body temperature], it can handle only one thing at a time in the foreground. You can be doing several things at once, but you can pay attention to only one of them."[9]

Finally, we'll discuss in Chapter 7 how being in performance mode allows—no, demands—that you are fully present with the patient, paying attention only to the person in the room with you. This enables to you perform at your peak as a physician.

A good performance enhances empathy.

Being fully present requires that we listen and observe, and these actions are essential to a good performance. They activate the mirror neurons in the premotor cortex and inferior parietal cortex. One theory is that this mirroring is the physiologic basis for empathy,[10] so crucial to being a great physician and connecting with patients. The greater the empathy we have for our patients, the better their experiences with us will be. We'll see specific examples of how performance creates empathy later.

The workday goes by faster.

Most performers experience a time warp onstage. I know I do. When I am speaking to doctors and am in the "full flow" of giving my talk, I completely lose track of time, at least consciously. I somehow always know when my speaking time is up, but while I'm onstage, there is no time, and I'm amazed afterward how short the performance seems in retrospect. I found the same thing seeing patients in the office. Being in performance mode can make what promised to be a long, stressful day feel afterward as if it had flown by in a flash. The feeling was almost exhilarating.

Performing is fun.

If you're a musician, dancer, actor, or stand-up comic (yes, there are some docs who do that), you already know that performing is fun. If you've ever been in a school play, sung in a church choir, played in a rock

band, or told jokes to friends, you already know that performing is fun. Performing music—not merely listening to it—releases endorphins.[11] I'm sure that's true of performing comedy or public speaking as well. Invariably, the first thought that goes through my mind after a successful speech is, "Where can I get more of *that*?" And after a good day of medical performance, I'm eager to come back to work the next day. How often do you feel that?

Making your visit a performance satisfies patients.

Surveys show that there are just a few things that patients want from their doctor visits. To understand how a good performance satisfies those desires, we'll turn to them next.

TAKEAWAYS

- In our lives, we have many selves and perform many roles.
- When we see patients, we are being the biggest, best version of our physician selves.
- Good performance is authentic behavior in a manufactured environment.
- A good performance enhances empathy.
- A performance is enjoyable.
- Making your visit a performance satisfies patients.

ABOUT THE AUTHOR

Bob Baker, MD is an internist/gastroenterologist who left private practice after 35 years in a multi-specialty group in Great Neck, New York. He has a special interest in the doctor-patient relationship and served as a Physician Master Facilitator for the Culture of C.A.R.E. program of Northwell Health, one of the country's largest health systems.

Dr. Baker is a graduate of Princeton University and the College of Physicians and Surgeons of Columbia University. He trained at New York Hospital/Cornell Medical Center and completed his fellowship in gastroenterology at Beth Israel Hospital/Harvard Medical School.

He is also a professional magician and ventriloquist who has appeared on *America's Got Talent* as well at as numerous private, corporate, and fundraising events. His performing skills play an important role in making him a highly-praised, in-demand keynote speaker for doctors, nurses, and other healthcare workers at medical conferences and meetings.

Dr. Baker lives on Long Island with his wife and whichever of his seven children happen to be around.

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