Mark Masselli (00:04)
Fed up with the healthcare system, tired of the corporate control, maybe the patient revolution is what you need to learn about.

Dr. Victor Montori (00:11)
Figuring out what needs to be done, where they are to, move away from the processing of people, focused just simply on access and efficiency and throughput. And instead thinking about how do we, support, clinicians, whether these are therapists, pharmacists, nurses, physicians in noticing, what is going on? What is the problematic situation of this person?

Margaret Flinter (00:37)
Our guest today is Dr. Victor Montori. He's in the top 1% of the most frequently cited health services researchers in the world for his work on shared decision making and minimally disruptive care. And he's leading the patient revolution.

Dr. Montori (00:51)
Our movement seeks to turn away from the industrialization of healthcare, where the processing of people, is, what replaces caring.

Margaret (01:03)
This is Conversations on Healthcare.

Mark (01:16)
Dr. Montori, welcome to Conversations on Healthcare.

Dr. Montori (01:20)
Thank you for having me.

Mark (01:21)
You Know, you're a practicing endocrinologist at the Mayo Clinic and author of the book, “Why We Revolt” and you head up the Patient Revolution. I, I will say revolution is a strong word to, but I wonder if you could describe your views for our listeners.

Dr. Montori (01:37)
Yeah. And, and we don't mean that word, as a branding or, or a cute thing. I think we have to remember that the word revolution, is, you know, it's turn, it, it implies turning. And our, our movement seeks to turn away from the industrialization of healthcare, where the processing of people, is, what replaces caring, which is what people expect when they come into healthcare. And, and when you turn away from industrialized healthcare, we hope that what we turn away to is not further, you know, artificial, forms of care, but rather careful and kind care for all. And so we have a, a global movement that is trying to achieve that, worldwide.

Margaret (02:28)
Well, I think you, you catch people right there when you say kind healthcare. I think everybody seeks that. You work as a group to investigate, and disseminate the evidence. That quote helps illuminate the negative impact of industrialization as you just described. but you do this through, what you term the greenhouse. Tell us about the greenhouse.

Dr. Montori (02:49)
Yeah. So our, our movement, the patient revolution has three major programs. one is the community of, care activists acting all over the world. These are care, patient revolution fellows who are acting locally, figuring out what needs to be done, where they are to, move away from the processing of people, focus just simply on access and efficiency and throughput. And instead thinking about how do we, support, clinicians, whether these are therapist, pharmacists, nurses, physicians, in noticing, what is going on, what is the problematic situation of this person? And then working with that person with both competence and compassion in responding, well, to that to, to what is going on in ways that really advance the patient's, situation forward. So that community of care activists is what we support and we support in two ways. One is through a school that, offers courses on what is, what is, what do we mean really by careful and kind care, and how might we bring about change at scale in, healthcare systems worldwide. And, greenhouse, which is what you, what you asked me about, which is the place where we try to create novel solutions, both in terms of, understanding, thinking about things, and, thinking about how to frame them and, and name them. Sometimes that's the first step in creating change. And

then also coming up with tools and policies that might, might just work in bringing about careful and kind care for everyone. And, and, and with those two supports, we think we can, help our community develop the skills and courage to make that change.

Mark (04:41)
Margaret, Dr. Montori just said it was, beyond the United States seemed to be a global movement. Maybe you could tell us a little more about the work that you're doing with fellows around the world and, what are the goals for the fellowship program? That sounds like it's international in scope.

Dr. Montori (4:59)
Correct. And, the, the, it's interesting. I'm originally from Peru and, I've done all my career in the United States, all my clinical career in the United States. And when I, with my colleagues set out to do this, initially we thought that there's, the scope of the change that was necessary was mostly, you know, within the United States, but we quickly recognized that around the world, there are many ways in which healthcare systems, and that up not providing the necessary conditions for people to either give care or receive care. in some countries it is because of policies of austerity, and those publicly funded systems, you know, have not invested enough in, in healthcare. As a result, those resources at the time, patients and clinicians come together, they're just not there. And so people have to be seen very quickly, without, without proper attention to what's going on and without the technologies and, and the thoughtfulness of actually, resolving their problems. In other places, like my home country, it is a combination of poverty and, and, and, and mismanaged resources and incompetence and corruption, that actually brings that about, if not just simply greed. In, in the pursuit of profits in the United States, we have a similar combination of all three factors, depending on the different healthcare systems that we talk about. So in all those cases, the final common pathway of all these problems is not enough time, not enough resources to care. And so the movement has to necessarily be global. Our, our fellows are our folks that come from all, walks of life. There are patients, there are caregivers, there are designers, engineers, lawyers, healthcare professionals, administrators that, that remember why they either sought care and didn't get it, or why they went into professions or of, of healthcare to care, and then find themselves unable to do so. That voltage between what should happen and what does happen gives them energy to bring about change.

Mark (07:01)
But if you looked at what should happen, what does happen, what's the, what's the business model behind it, because in some ways you're, opposed to what's currently happening in, in the financing structure. What, what, what does this model look like? Is it a fee for service world? Is it, how, how does it work?

Dr. Montori (07:19)
Yeah, I, a lot of, discussions about healthcare focus on, you know, what is the business model. but it's interesting that I think initially the core question is, what is this for? Healthcare is an investment that we make, in each other to advance our flourishing, to prevent disease from, representing a limit to our ability to realize our hopes and dreams. And as an investment, just like education, the question is really not what is the business model so we can get value for money. It is first and foremost, how do we make sure that that mission gets realized? And so I think that debate has been worked by an effort to make sure that when you create a business model for healthcare, not only is there enough money to pay for everybody that wants to be paid, but there's also opportunity for profit making, both by the pharmaceutical industry, insurance providers and device manufacturers and other folks. I think the discussion first is what do we want to really offer each other when we invest in healthcare? Then we might actually uncover different and innovative models that not only enable that investment to realize, its purpose, but also, make it sustainable and capable of innovation. That is an open question, and that's, I think, something that is, open also for revolution.

Margaret (08:48)
So, Dr. Montori, as a nurse by profession, I certainly was, schooled deeply in the science of caring and, some of the strategies that nursing uses to bring that into daily practice. But I think the thing we all learn along the way is you've gotta have structure and supports that make it possible for you to do what you set out to do. And I think that's true in medicine, in nursing, in any other, of the, of the health professions. Maybe share an example with us, if you can, with your students and the others, that work with you in this area. How have you been able, do you have some examples to design this care environment differently or the strategies, I think we can say with pretty high degree of confidence, people come into the health professions wanting to help, wanting to care, and they bump up against a lot of obstacles, time, of course, being one of the key ones. But tell us about some of the things that you have found successful in your work over these last many years.

Dr. Montori (09:51)
Yeah, to, to your last point, to start there, I think, the current healthcare system, no matter where you look, is, is it's unsustainable financially, environmentally, but profoundly humanly unsustainable clinicians, as you point out, show up to care, and about 40% of them are thinking about quitting their profession, or le quitting clinical care. 40% of patients who live with multiple chronic conditions are overwhelmed by the tasks that healthcare transfers to them. So, so we really are looking at a system that is supposed to promote human flourishing and yet is humanly unsustainable. One might be potential ways forward. It's amazing because you don't have to invent many of them. You just have to observe carefully where people, like you said, motivated by the right thing, have been able to, do this in, in ways. And just make sure that you share that with folks that might not see that or know that, and then they can do it. For instance, simple things where I work, the building in which I work was designed in the fifties, 1950s, and back then somebody decided to put, to put very thick walls, separating the clinical offices from the hallway and put cork floors on the hallway. And you think, you know, that's not the most, cost efficient way of building at the time. No, it was not. But somebody made that choice because they decided that what happened in those rooms was sacred and had to be, had, had the content had to be kept private in those, in those offices and the conversations that we wanted to happen, because that suggests collaboration in those hallways should not be led to interrupt what is going on in those offices. So it's interesting that architecturally we've made some decisions about creating the conditions for care, that you can observe in, in, in different offices. But if you go to some modern ones, you will see that the choice has been made related to cost, you know, thin walls, thin, thin doors, and, and noisy hallways. the, the content of the interaction, how patients and clinicians come together. We've introduced electronic health record systems that actually sit often between the patient and the clinician demanding attention, where the clinician has to spend time documenting care, often at the expense of caring. And so there are models now to actually try to set aside the computer system to actually focus on the conversation.

Mark (12:10)
You know, I do wanna pull the thread back on the, on the, on the model here, because we come from the community health center world where healthcare is a right, not a privilege serving a low-income population. We have to think about “how do we sustain that and what's the practical reality.” So this vision, which you have around a patient revolution, can spread. And so it's not a bad thing as much as if we don't do that, then we are doing a disservice to the population that we serve. So, thinking about the population you serve, really trying to move all the noise out about, business and the, like, you, how do you, how do you see this sustaining itself and growing? Because I assume that's what you want to have happen.

Dr. Montori (12:54)
Yeah, I oftentimes, we think that the best conditions for care can be found in places that, cater to the, to those more privileged. but some of the best examples of careful and kind care are from, safety net hospitals, community health, centers, refugee care. one, I was once at a, at a conference where a, leader for the refugee clinic in Denmark was giving, was giving a talk, and he was describing a patient situation and of a woman who had, gone all to Denmark, all the way from Syria, with, you know, tremendous exposure to harm and trauma. And by the time she came into the consultation, she was experiencing some, unclear symptoms. And, and she said, well, and, and, and the, the clinician that was giving the talk said that he just sat down and, and was talking to her, listening to her and trying to understand her situation. And about an hour into their conversation, he was able to figure out what this, this woman really needed. And so I raised my hand, said like, wait a minute. You're running a, a refugee clinic that is outside of the Danish healthcare system that is massively underfunded, incredible demand for, and you gave this woman one hour to figure out what's wrong. Yeah. And he, he was taken aback, and he, if for him, it was pretty obvious that he had not expended that hour, if he had responded quickly with a test or a treatment, that that woman would've actually ended up in the back of the queue again, and this would not have resolved this problem of demand. And so it's very interesting to me that those people who really are involved in this know that it, there's something beyond simply attending to the queue and just making sure there's enough access . And through proof, but there's actually needs to be care. And in with, if you cannot care, then your system is just given the illusion of access to care without care itself.

Margaret (14:47)
You know, it's interesting, I think, Mark, you would agree with me that some of the most, attractive positions within our organization are those that take our providers to where the patients with some of the most complex challenges are mobile health units, homeless shelters, migrant farms, and, and what they have in common, of course, is an intensity of need, but also less of the focus on the interval of time that you have to see the patient. So the, the good news is those patients really do get an intensity of care.

Mark (15:20)
And, and their programs that and where the patients are, versus where we are.

Margaret (15:24)
Yeah, exactly. But I, I think it's, it's one of the, interesting, sort of realities of our life right now in, in healthcare, certainly in primary care, that the thing that may bring us back to more face-to-face time without the barrier of the electronic health record in front of us and typing away during visits is ai, right? A technology intervention that will scribe our notes, code, our procedures, and diagnosis and billing, and maybe give back to people a little more of that very human intensity of focus. And I'm wondering if that's been your experience in your health system as you've probably integrated electronic scribing and coding and so forth. Is there a, dare I say, a contribution to more joy and practice through having more of that opportunity to be in connection with patients?

Dr. Montori (16:18)
Yeah, I think there's a, there's a duality there, right? On the one hand, there's this issue of proximity, closeness, connection that you describe as essential here, which, there's an enormous pressure right now to digitize. And, and so with the, with the idea that we can reach more people at lower cost at all times, if we just do digital first, and yet you've highlighted, I think, correctly, that a lot of the care that is really necessary is thrives in environments in which we get to proximity. At the same time, there is technology that can actually get some of the stuff out of some of the stuff that is unnecessary for care out of the way. So one could focus and be present and be able to respond well. we've actually implemented where I work, an AI system that does what you described, you know, produces a note, without us having to take notes and so forth. And I've used it myself quite extensively, and I noticed a couple of things. First, that I can, I can be more, attentive, to the conversation with the patient without focusing so much on the documentation, even if I, it was my practice, not necessarily to document directly on the, on the computer, but actually take notes by hand. But even that, it becomes unnecessary if this system is capturing, most of the information. The, the second part of that, which is interesting, is that it produces a note, but it's a note that doesn't necessarily reflect the, not the content, but the flavor of the conversation I just had. And so compared to the notes that I would write myself from scratch to these ones that are produced for my editing, which I ended up doing quite a bit of editing, these notes have all the information, but they don't have any of the flavor, the story of the right of, of the interaction. And, my metaphor is it's almost like fluorescent lightning where you actually want incandescent light, you know? And, where we want warmth, and you want shadow, and you want nuance, and you want volume, it gives you flat truth. And I think there's an opportunity, which is why I spend the time in editing, to make sure that that note reflects our conversation, particularly because all our nodes are available to our patients. And I don't want my patients to think that, what they experience in the one-to-one interaction, which I hope is warmth and connection, that it doesn't, it, it was fake and was true is what is reflected on the note.

Mark (18:42)
You know, I you just set a phrase that I wanna pull the thread on. Thrive in an environment. So let's a little talk a little bit about your environment. You're in the Mayo Clinic, which is the largest integrated not-for-profit medical group in the world. so I have to ask the question about thriving. What's, what's the reaction from Mayo and your peers, to your call for a revolution and this model?

Dr. Montori (19:06)
Yeah. It's, it's always strange, right? Because, we're supposed to be, I think, never satisfied in trying to pursue the patient's best interest. That's, that's what drives our organization. At the same time, Mayo is not immune to the same influences and, and, and, and environments that other organizations are being affected by, which are forcing, the change in, in, in, in healthcare. Some of it for good, some of it perhaps in undesirable directions. So, I think all, every organization like Mayo has its own strategies to adapt and, and, and, do better in different environments, including its own innovation and, and process improvement approaches. Revolution is usually not in the script, right? It's not, it's not in the list of things that is not in the capabilities of an organization. In fact, organizations try not to, upset themselves too much because they have a, in particular places like Mayo have an organization that actually makes it very effective, as a way of responding to people's challenges. and yet, you know, you look at the direction of the healthcare system and you look at the direction of patient need, and you think, Hmm, you know, there seems to be a mismatch here, in which people are being processed instead of receiving care in which caregivers are showing up, and yet they're finding themselves, facing moral injury and quitting what is actually one of the most in incredible ways of, making a living and being a human. So, so there's something fundamentally wrong, and I think the call for revolution, is a call to pay attention to the fundamentals and make sure that in the, in the face of all these potential technological developments, that we don't lose track. That the fundamental thing is that the care is human, and that, that we shouldn't bypass the humans when it comes to offering and receiving care.

Margaret (21:00)
Well, we live in interesting times that sort of become, you know, almost my standard. What I say to myself in the morning when I wake up, part of these interesting times, of course, is what's going on nationally. We've been talking about some of the special populations. We all care for, the, the desire to, to do good, to care, to bring science and caring, together. But we've, just seen the president has signed the, the one big, beautiful bill. and a, clear consequence would seem to be that people we may have traditionally cared for will find themselves without access to care, that there will be limitations. We're seeing some of the trauma of individuals and families who, face, deportation, probably one of the greatest traumas that can happen. I'm curious in, in your organization, and I, I think, most of us . Without knowing Mayo directly, the reputation speaks for itself, as an organization with principles and, a set of values. How are you handling, anticipating these changes or some of the changes that are already here as an organization, as a medical staff, nursing staff, ethicists, the, the folks that staff the Mayo Clinic, as you think about some of the big challenges ahead?

Dr. Montori (22:15)
Yeah, I, I, I, you know, you, you have to ask that question to, to the organizational leaders in terms of their ability to respond. I can tell you that all of us, sort of at the ground level in responding to the, our, our needs for our patients, we have to pay attention to the, the fact that as the world becomes increasingly, you know, develops these policies or lives through these policies that are increasingly cruel, that individual, individuals are actually suffering, and that we know that the suffering, the, the kind of structural suffering that, people are experiencing is the kind of suffering that drives, chronic disease, both in terms of mental and physical health. deterioration is requiring more and more clinical care, and it will be a mistake. And I think all of my colleagues and I recognized it to respond to that exclusively through biomedical means. . And I think the current circumstance requires us to not only pay attention to the patient in front of us, but actually pay attention to the societies and communities in which we work and figure out and think through and act to actually bring about, better conditions, more, more, more, more just conditions in which people can actually, thrive. healthcare, again, is a way of reducing the, one of the barriers for people's, realization or, or flourishing, which is the barrier introduced by, disease and in fact, sometimes by treatment. but this, some of these policies that are, fundamentally cruel, actually introduce further barriers for the, the realization, of, of the opportunities and capabilities that some folks have. And, it will be limited in our, if, if our scope, was limited to what we can do in the, in the office. And so, as part of our, our work, I think we all recognize that we must all be advocating constantly, openly and loudly for, a more just, world in which the policies that we, institute fundamentally advance our ability to care for and about each other. That true freedom comes from the ability to do what we want to do, to live in the ways we want to live, knowing that if all falls apart, we, we will receive the care of all around us. I don't think that we are at that point or not any, anywhere close. And so as a result of that, the, the, the work towards freedom is incomplete.

Mark (24:42)
You know, Margaret, you were talking about changes in healthcare and certainly, doctor, your, endocrinologist working on some more important issues, and you're focus in Mayo Clinic on caring for patients with diabetes. And speaking of change, it looks like that world of diabetes is going under tremendous treatment change, with these new GLP1 drugs. I'm just wondering what your view is on that particular medication and that particular intervention.

Dr. Montori (25:11)
It's, it's one more tool in our toolbox. It's one more way in which we can, help people with diabetes, live, live longer lives, live lives with, with fewer limitations. Traditionally diabetes treatments have lowered blood sugar. Think of that, I'm talking about patients with type two diabetes. Patients with type one diabetes, of course, depend on insulin for, for their to, to live nowadays full lives, with almost no limitations, but a lot of work. but patients with type two diabetes, have, historically their treatment has focused historically on lower blood sugars, which is the same as if you were to say that the way to fight off infection is to focus on fever instead of fighting off the bug that caused the infection. Right. And so in diabetes, we've had a hard time figuring out what's the bug. And so we've managed to, to always fight against blood sugar elevations and bringing down blood sugar. So some of the new drugs among which is this GLP1 receptor agonist that you mentioned are now, seem to be, driving interventions into somewhere closer to what will be the equivalent of that infection instead of focusing on the symptom, the fever. And as a result, we're seeing patients, not only losing weight, but also reducing the risk of developing, complications of diabetes focused on the heart, the liver, and the kidney, or even sleep. And all of these are good news for our patients with diabetes. of course, the companies that produce these drugs, have managed to produce them at a time in our, in our human evolution where profiting with massive profit margins for these drugs, is, is, is now expected, and that is putting this, fundamental, tools in our, of our toolbox outside the reach of many of the employee.

Mark (27:08)
It's obscene.

Dr. Montori (27:10)
Correct.

Margaret (27:12)
Well, on the, list of things that give most people in healthcare joy, in practice training, the next generation is often high on the list, the ability to welcome new people into the professions, all of them, to influence them and to, try and impart the best that we have to share. What are you seeing in the generation of, students, of the health professions that are coming into the Mayo or other institutions you work with? They're looking at a generation before them that, as you say, may be experiencing burnout at unprecedented, levels. What are you doing to help them get on a track that allows them to really keep that joy and commitment that they came into it with?

Dr. Montori (27:53)
Well, I, it, this, I'm waiting for the, for the easy questions, but, this is a very, We don't have any Yeah, yeah, yeah. This is a, this is a very interesting challenge because, some people are going into healthcare, having bought the notion that healthcare is an industry that represents, you know, I don't know, 20% of our economy, the biggest employer in most states in the United States, and therefore an, a business opportunity, beyond the, the, the usual, you know, making a living aspect of healthcare that perhaps brings in nurses and doctors and other folks in, in direct patient care. And many people are actually going, for instance, to medical school, not to take care of patients, but actually to join the, the, the ranks of, of biotech executives and, and other folks in that realm. I think that's, okay, I presume, but seems to me like a missed opportunity. At the same time, I think there is a, a swell of, of a, a new wave of, young people who are looking for a to be, to, to dedicate their lives to something bigger than themselves. social media has given them a world that is very small, that is very superficial. There's, that is, that offers, it, it cheapens, existence and they're looking for something more, meaningful, in their lives. And there's nothing more meaningful that dedicating your life to the care of other people. . And, and so it's very important that those who have, a voice in healthcare, whether they're healthcare executives or healthcare professional leaders, anybody that has, the chance of using their voice, they need to remind themselves and others that the fundamental reason we have these organizations and these careers and these opportunities is because we're here to care for people. And the moment we betray that is the moment we, once again, give up, on the potential enormous potential that young people have to bring about a better world, in this case, a world than in which, the main thing we do between humans is to care for and about each other.

Mark (30:19)
Well, that's a great note to end on. Dr. Montori, thank you for joining us today. Thanks to our audience for being here. Just a reminder to be sure to subscribe to our videos on YouTube and find us on Facebook and X and you can also share your thoughts and comments on the program. Take care, and be well.

Margaret (30:38)