Podcast Episode Transcript: Travis Bias and David Butler

Travis Bias: Welcome. I'm your host Travis Bias, Chief Medical Officer of the Clinician Solutions Business, housed within 3M's Health Information Systems Division. Today I have with me Dr. David Butler. Dr. Butler, welcome.

David Butler: Thank you, Travis for having me.

Travis Bias: Dave is a bit of a physician informatics anomaly. He served as Chief Medical Information Officer or in CMIO-like roles in four large health systems across the U.S. in the past 20 years, from Geisinger to Texas Children's Hospital to Bon Secours to Sutter Health. He's a dual boarded internist and pediatrician who has worked in the acute setting as a hospitalist and in the outpatient setting in general practice. Currently, he's serving as interim CMIO at Key Care, an innovative startup based out of Chicago and led by another physician entrepreneur, Dr. Lyle Berkowitz.

We've definitely heard about Key Care, Dr. Butler. So interested to get your thoughts on that. Dr. Butler started a consultancy called Calyx Partners, which specializes in physician training, communication and workflow based technology tools to ensure our new digital black bag has the most effective and streamlined tools to care for patients in 2023. And I've seen you describe as a ridiculous optimist when it comes to the pursuit of the quadruple or quintuple aim. I love that. We need optimists right now.

So a long way from his humble beginnings in Texas where he was fully educated and trained, starting at Texas A&M University to the University of Texas Health Science Center at Houston for medical school, and then onto Baylor College of Medicine for residency training. And so our Texas roots is one of the many things that we share, although your credentials and experience exceed my own.

David Butler: Nope, I've seen the B sides of Travis Bias. Yeah. I've seen it. You've got a volume of work, buddy. We're not doing that.

Travis Bias: I appreciate that. So let's start from the beginning. I mean, when you were setting out into clinical practice, what is it that you were wanting out of your work environment and how have you seen that change in the last 15 years in terms of what physicians are currently looking for?

David Butler: No, solid. I think I was a bit, maybe not the word naive, but a purist I think. I grew up watching The Cosby Show, Cliff Huxtable, not Bill Cosby. Okay, won't talk about that, but that was my idol. I wanted to do that. Then the ER came out with Peter Benton, wanted to be that surgeon and all that.

I remember in med school I was class president and so we were trying to raise some funds for something called the End of Basic Science Banquet. And so I had an idea. We record ER on

Thursday night, on the DVD VHS, and then we show it the lecture hall for a dollar on Friday. Dude, we made a killing.

So yeah, so I had a little bit of entrepreneurial spirit. As I look back, I think that's maybe where it started too, but that was just a side note. Yeah, so I think I was a purist when it comes to all that. I wanted to be a doctor. I wanted to see patients. I wanted to be the traditional, I'll call it the Norman Rockwell type doc, where it's just I want it to be a relationship, the long-term game. And then when I first started out of residency and got to Geisinger Health system, this was 2003. Honestly, I tell folks Geisinger was always cutting edge on they own their doctors. They moved fast. The technology was already there. Epic was there in 2003. I got my first MyChart message in 2005. And I literally backed away from the computer like how did my patients get to me?

And that tells you a little bit about how innovative Geisinger was, right? So they wanted Epic's first six clients or so they did it before it was cool. No meaningful use, high tech act. So that was the company that I joined out of residency. I think that helped establish who I was going to become over the next 20 years as far as a position. And I think being a 51 Gen X we're the first generation probably that had to check email in med school. And I wouldn't say we, you're younger than I am, maybe, but you look old. But anyway. I'm just saying you look-

Travis Bias: I'm a geriatric millennial.

David Butler: Yeah, I like that. Geriatric millennial. I like it. Elder millennial as one of the comedians. I like that. So yeah, so that was me. And so when I hit it, I was so frustrated I could not practice the way I wanted to practice because this computer kept getting in the way. And I was like, oh my goodness. The guys across the street, they're seeing patients effectively, good quality of care in the paper-based workflow. But this technology that we were using at the time with Epic, it was early. It was clunky, kludgy. And that led me to kind of get a little frustrated.

Wait, this is taking way too long. It's interfering with my patient physician, relationship though. That's when I kind of started causing fusses and asking about, why is this button here? Why is this here? Why can't I do this? And that led the executives to hear some loud mouth new guy from Texas is talking about our electronic health record system and ultimately came down. It was like, look, here's how it works, man. We all know it's some problems there and we're looking for help. And they asked if I wanted to help out. Absolutely. And that's when I had to first learn the language of IT technologies because this is where our digital black bag.

They now own my black bag. I did not like the fact this computer could log off every five minutes. And I'm like, what is going on? I have to put my password back in. And I could not find an answer, why? And IT was just like, well, it's just the way it is. It's the way it is. They would throw their hands up. And I refused to give my entire livelihood over to technologists at this time. And that's why I felt like I needed to be a little bit more involved in the tech. And that has been my origin story, I'd say.

Travis Bias: No, I think that's a fantastic origin story. And I think going back, I think some people don't remember the kind of basic beginnings of electronic health records a couple

decades ago. And how with me in residency, I remember when I was seeking out residency positions, I was looking for a program that had an electronic health record in their clinic. That was a new thing that a couple of programs did and some didn't. And I thought, this is the future. I need to be trained on this. But I remember how frustrated I was trying to not only learn medicine, to learn what the ICD-10 CPT codes were, but then also to learn the electronic health record and how to navigate through that, in amongst learning all these other tasks.

And so I would think for you, for me, what I was looking for early on was just a little bit of autonomy over my work environment, over my domain. Whether that comes from scheduling or within the electronic health record. In your example, you were kind of able to take a little bit more control over that, which I imagine was a good feeling upfront for them to at least acknowledge like, hey, this is an important thing to have a clinical leader as part of.

David Butler: Absolutely. And I think the biggest thing I was surprised at is that the doctors that had been using this system for two or three years before I even got there, they weren't even complaining, anymore. I'll say, because sometimes you know how it works. You complain, complain. When you don't see any easy solution, you're just like tuck in and get used to it. I call them antibodies. You get antibodies.

I think they just got antibodies, the clicks or something. And I was not going to get antibodies to clicks. I was not going to do this because I think my aha moment was when my son had... My in-laws got him an Xbox when it just came out early two thousands, right? They got him a Xbox. Well, he was only four or five. That was during the time where Wii, and I think it was the Nintendos or something, they'd just come out. That was branded towards five to seven eight year olds. That's what they should have gotten him.

Well, they sent an Xbox that was branded for teenagers. And the game on Xbox was Halo. And I remember I hadn't gamed since college, Techno Bowl or whatever. So I was like, hey, I'll take this and I'll get him a Nintendo and say it's from the grandparents. So when I got on it, though, this joystick was so complicated. This controller, they call it. I called it a joystick back in the day. So the controller was so complicated, I'm like, this is crazy. So I fired it up one morning in the basement and all of a sudden it was so interactive. It was three dimensional. And they said, hello, master chief. They're looking at me as if... Because I'm looking through my eyes. It's like a first person shooter.

And it was so elegant and beautiful. I just started wandering around these fantastical worlds that had trees, lakes, sun. And I had a mythical sniper rifle, not a real rifle, of course. We don't do that. I'm a pediatrician, Travis. And so you're walking around these worlds with this sniper rifle, and then you see a shadow of your rifle on the gun on the ground, right?

Travis Bias: Yeah.

David Butler: And it hit me, wait, there's not even a real sun Travis. How is that a shadow? And I realized, wait, this whole game is made of ones and zeros. And when I would go into my office, this kludgy EHR that I'm using to save lives, it was nowhere near as elegant as that or easy to use or prompt. It was very fascinating. I think that was aha moment because as

doctors, we didn't make the model that we treat. Well, like a computer, a human made that, right? And so if you break, it's going to take a human and fix it.

And engineering. Engineers make a lot of cool things. And if this side of the equation doesn't equal that side, they know how to debug it and fix it because a human created it. And I think I had just gotten so used to that mentality of a human where if it's like this and it works like this, then it must just be. I'll have to create duct tape around it. That's what medicine is and all these other stuff. So once I broke that mindset and decide, no, a human made this, a human can fix this. I need to find the humans. And that took me in a whole different direction to make sure that I was not going to accept the digital black bag that they gave me.

And that that's what I think our whole generation of the paper... I call us the paper to pixels generation. We made that transition. So a lot of the younger docs, they're coming out on easy EHRs, which is cool. But I find that those docs may not even understand that a lot of the things on those screens can be changed. It's not like the iPhones. So anyway, I feel like you said, getting back your autonomy, that's huge. And that's going on with physician burnout and everything else.

Travis Bias: Yeah. So you mentioned burnout, and I think we started talking about the electronic health record. And that's become a center point, perhaps fairly or unfairly. I mean, physicians spend the majority of their time at work within the electronic health record. And so that has become a center point of frustration for physicians for a lot of different reasons. And burnout has really become something that we're talking more and more about, which I think it's a good thing that we're talking about it in the way that we're talking about.

But physicians across the country are going to their CMOs or their chief medical officers or chief medical information officers begging them for help of some kind to combat these feelings of burnout and the systemic frustrations that they face. And I know this because we hear that from clinical leaders that we meet with regularly. So how are you seeing this? Because I know you engage with CIMOs and CMOs across the country. How are you seeing them confronting this challenge at their organizations?

David Butler: Various ways. I've traveled all over the U.S. over the past, say seven, eight years, consulted with over probably 20 different health care organizations. I'm mainly around physician workflow or physician frustrations with the technology. [inaudible 00:11:35] we bought Epic, we did this, we did this. They're still not happy. We hear a lot of white noise. And a lot of times I'm getting called into help find the signal to make sure there's... Okay, here's what you can fix. Here's what you can change. Here's how you need to apply it. It could be people, process or tech, not just tech.

And what I'm seeing over and over is that a lot of these companies have really invested heavily, capital funds operating dollars into implementing largely electronic health records, digital roadmap, digital front doors, and all this technology. And they've created a lot, especially since the pandemic. They've invested a lot in the digital to get patients access into their health systems. The front doors, side doors, stage doors, you can call it, windows. And now I feel like these planes are landing now and the doors are open and patients are showing

up. But you know what they're showing up to, is burned out docs. Burned out staff. Staff that are overtaxed and where the patients actually have better tech than they do.

And so they're getting over teched by the patients and adding to some of the burnout. So I am hoping that health care systems, I don't care what they're doing now. I'm hoping that they will start... Well, I know what they're doing now. It's not a lot to be quite honest. Studies show this. Monies are real tight right now. They're not spending on tech, they're not spending on folks. And so they're trying to retain staff. They're trying to do more with less. But I have not seen them approach it from an operations clinical and tech perspective. That triangle is huge, Travis.

Meaning what they'll do, they'll throw tech at it. Well, Epic's coming out with an upgrade in In Basket, so that'll make them happy, right? No. What'll make them happy, if there was some policies and processes around patients emailing in. What does that mean? Hiring new staff that may take all those messages over here, offset that or invest in serious less... Just invest in say AI type things.

What Epic and some of the big vendors are doing now, they're grabbing those message and helping the chat bots triage that better, much more effective than a human can do at this point. And so I'm hoping that that's where they're looking. They're looking very seriously at it. And hopefully they're balancing some of the security and those cybersecurity concerns that have just derailed a lot of really great technology from touching the doctors due to compliance departments, risk and legal. They're a little bit more conservative than I feel like they should be. And that's my experience of 20 years.

Travis Bias: Sure. No, that makes a lot of sense. And I know you have this kind of this vantage point across the entire health care system. I mean, we've seen each other at several events from HIMSS to Epic's user group meeting to others. So what are some others. You mentioned the front digital front door and some In Basket triage type tools. What are other initiatives that physician and informatics leaders are looking to undertake right now, right now that are helping to tackle this burnout issue?

David Butler: I think I'm seeing a lot of cool things around In Basket. In Basket's it's one of those areas that a lot of time can be spent there with zero compensation and zero even psychological reward.

Travis Bias: And we've seen even the number of those messages tick up massively during the pandemic.

David Butler: Yeah, they're up and they've stayed up. And so folks have chosen efficiency over effectiveness, I feel. And it is what it is. I've heard, I think Steven Covey says, you can be efficient with things, but you be effective with relationships and people. And so the Zoom meetings, we do a lot of Zooms. You can get eight a day, Zoom meetings, but when you're burned out after the first four, what is the other there? What is the real win here?

I think we just have to make sure we balance the amount of technology, the screen time, and all these other things that are just bombarding our physicians, nurses, the mental not only at

work, but at home. We've got to balance some of that stuff and figure out how do we offload some of this from those physicians. And especially the primary care docs or the nurse practitioners and PAs that are frontline. And that's whether they are in a clinic or whether they're virtual, like Key Care.

What we do at Key Care is we're virtualists. That's what we do. And I think you've provided virtual care. And you can tell it is not as rewarding as going in those patient's room, looking at their face, putting a stethoscope on them, letting them hear their bowel sounds and letting the kid next to hear their bowel sounds. Things like that. That's why we went into medicine. So those behavioral economic rewards are gone, to a large extent. And I'm an optimist, remember. So this is from an optimistic perspective. And I feel like the physicians don't see a lot of hope in sight.

And so that's what I hope that we do is we jump all over this generative AI stuff. I played with this for six months as an enthusiast. I've studied it. I've used it to really streamline some personal things that I do. Everything from transcribing really complicated meetings into something meaningful. To my friends may text me, Hey Butler, my mom had a breast biopsy. Here's results from MyChart. I look at it, grab it, put it in GPT. No, PHI, of course. And I asked Chat GPT, hey, act like a breast cancer surgeon and yet also a patient advocate who specializes in explaining complex things to patients and use metaphors and analogies.

And then what it comes out with is so beautiful. And I verify it first and I copy it and I send it over. And it's just simple. I've done that multiple times with just family members. And I'm like, this is easy stuff. And I'm hoping that we don't let too much bureaucracy get in the way of this kind of narrow solutions going out to folks that need it. And hopefully they're not emailing the docs asking this where they can now just go to Chat GPT 4, which studies have shown it can do pretty good.

Travis Bias: Yeah, I think there's a huge balance there, right? Between taking output from that wholesale and then kind of funneling the output from some of those gen AI tools through the physician or through their caregiver or care team to help care for them. So yeah, I feel like for this generative AI, we are at peak hype right now. And so what are you telling leaders? I mean, you give a very great case example of how it could be used by patients or by physicians or by your family members. But what are you telling fellow clinic leaders about where we're going with generative AI and either for health workers or for patients and either where it can help today or where we're going in the next few years?

David Butler: When you say clinical leaders, let's say the leaders are one that actually write the checks. The one that are responsible for the direction of a health system. I find that those level of leaders sometimes just have no idea really what it is. And it's no fault of their own. This came up out the blue in November, December timeframe while everyone else is working 40, 45 hours a week doing what they should do. But right under everyone's noses, this thing came out. It's really hard to explain. It's the coolest technology I've ever seen, and yet it's the scariest all in the same time. And I feel both ways all day every day. So there you go about it, but it's what it is.

And what I think what health care system's are going to have to do is do what... I think NYU did a really good job with this where they-

Travis Bias: I saw that.

David Butler: You saw that? It's like whoa. They just say, hey, you know what? We're going to have our own large language model, put it inside. So all that putting things out there and our information out, we're going to bring it in. We're going to train everyone, department staff and all this other stuff, how to use it, how to be productive in your day-to-day lives. And I thought that was just fascinating. They jumped on it and I think that's how you do it. They mix people, processes, and the tech. They're not just throwing tech, they're put policies around it. Guidelines training. They went ahead and did all that before it was even something to do.

So I feel like more health systems probably want to look at NYU and see how they pulled that off there as a institution of health care. Not just the doctors, no, the staff, the folks in the background. So I think if we really want to talk about transformation, we have to think of the whole entity that houses health care. So not just the payers, pharma and IDNs. I think we've got to go a little bit broader and approach this thing the right way and say, where do we put these narrow solutions and how do they integrate into some of the larger stuff like the Epics of the world?

Travis Bias: Yeah, I think that's a really nice example, the NYU example where it seems like they kind of took this grassroots approach. Or almost this attempt to democratize the use of generative AI, make it easy, but to do so within the boundaries of what they consider safe for their organization and for their patient populations. But I think that if you take that grassroots approach, it really seems like that's how we come up with actual practical use cases and ways of using generative AI in a way that's actually going to help a clinician today rather than something that in theory five years from now is going to help them.

David Butler: Absolutely, Travis. I think you dinged it. It's really difficult though, I realized, coming up with use cases. And I think that everyone that have used, whether it's Bard, Claude 2, Andthropics, Bard 2. Whether it's Llama, Palm, whatever, all these models that are out there. Anyone that have used it a little bit to take even create a rap song about Travis Bias by Snoop Dogg. Whatever. You can do this. Sound like Eminem and talk about health care. I just saw something, it said... This is funny. I just saw it yesterday on Reddit somewhere. I get to the dark places of the internet when it comes to GPT 4. Sorry.

But this guy said, hey, create a radiology report. He said, rephrase this as if you're a millennial. The jargons, whatever. And it was like, yeah, what's up fam? Let's take a look at this. It was really kind of interesting the way it read. It said, your bowels look dope. They're going to be okay. They kept moving down through the systems, but using very colloquial language. Now, that's the silly part of it, right?

Travis Bias: Sure.

David Butler: Now, flip it, pivot it. Say hey, look at this radiology report as if you are a seasoned radiologists in this particular area of the body and you understand the deep research

of this area. Tell me what you see here, but also give other things that I may not have thought of, yada yada. And it's going to follow rules. And so I think learning the psychological communication, how to talk or how to write into this thing will definitely dictate the outputs that it gives you. They call that prompts. So prompts or just for those that hadn't done it, prompt, prompt, engineering. Prompt is just what do you ask?

Almost if Google, because a lot of folks that may be listening have not tried it on their own. They hear about it, they've never logged in or tried it out and they didn't know what to do. That's what I'm learning too. And these are really smart folks that I've sent the links to, whatever, they just hadn't had the time. And so it's almost like Google. You ask Google, typically the human, we would have to dummy it down for Google. Let's say if I was looking for a template on rash or something. How would I create an e-visit form rash? So I would say, Google, show me a rash questionnaire. And all these things, sponsored ads would come up, this and that, yada yada. Now though, if you feel like a Google, but a deeper Google, you would say, hey, create a rash questionnaire for patients over, say 18 years old and be sure to yada yada. And you can go there and it just starts pumping it out.

It may hallucinate, they call it, a little bit where it'll miss certain things, but that's where your domain expertise in that area, you should pick that up. And that's why folks that may use it to create something that they're not truly a domain expert in, they may get a little embarrassed by the results. They say, oh, it doesn't work, whatever. Look at this story, it's so silly. It just wrote this story. It doesn't have a plot, a twist, and all this other stuff. Because it only gives you back what you put into it the right way via prompt.

Travis Bias: Yeah. Well, that's interesting that you bring up this prompt based scenario where really this is going to change potentially medical education and the way that we train up future physicians. But that is going to take a whole different, I guess, mindset shift, as you say, from looking something up in a textbook to just prompting something. But then knowing as a physician, I have to serve as the editor and better of that information that comes out of that. And I think that's going to be super important. A whole reeducation across the clinical community of all types of health workers that generative AI can omit key information, but it can also confidently hallucinate misinformation which can be super problematic when it comes to either clinical decisions or simply clinical documentation.

So I don't know what your thoughts are about in general educating physicians and clinicians around the use of generative AI. But just really the use of continuous education around the use of different types of digital tools or health tech tools so that they can take advantage of these within their daily work.

David Butler: Yeah, I think that's it. It's about educating them on you have a really big cool new tool in your digital black bag now, but it is a Swiss Army knife. And it's down there. And no one taught us how to, we weren't trained on it like we were trained on the otoscope, the stethoscope, or some of the other advanced procedures that we learned in training. And this is even bigger than the stethoscope, the otoscope. This is bigger than EHR even in a way, as far as training, how we approach and learn and use it to care for patients. I think you're right.

And I think we're so early in it that all, so much white noise out there about it. And I heard somebody call it, they said, AI is kind of like the Kardashians of health care. I was like, huh? Everybody's talking about it, but not many understand it's full potential. And I'm still trying to. I don't understand the Kardashians full potential either. I'm going to leave it there. But I thought that was interesting. It's like what's the hype and what's real?

Travis Bias: Yeah, there's a ton of excitement around it. And to your point, it's hard to nail down some practical use cases today. So I guess how do we describe beyond... Okay, it's going to support the work of clinicians. Sure. But how would you describe the benefits of generative AI even for patients or for population health? I'm thinking of improving access to care. Surely it's going to do that lowering costs. What else?

David Butler: Oh, yeah. No. I think access, for me personally as an African-American male from the South that have seen just egregious things that have gone on across the U.S. and the history of the US. In the systemic parts that make zip codes more important than the genetic code. And that's the history of the U.S. So what I see is that if placed in the right locations, this... And let's go simple. We're going to go narrow solutions, super simple, low tech, easy, if deployed today, it would help a lot of folks. And cheap. Okay.

I meant this bot. If my mother, and I've got to go back to another story. My mother was a nursing home nurse 40 years. And in this small town though, all my family members would call her and say, hey, Stella, having a stomach ache. Stella I've got a rash, Stella, this Stella that. Because she was the closest doctor in our family, and that's it. So now I think like, oh my God, Chat GPT can give mom a break from family members calling. And Chat GPT is going to be better than her. My mother, God bless, she's sweet. Mom's smart, but she listen's, she knows what I'm talking about. Stella. And so Stella is not as smart as Chat GPT-4 or 3.5 or any of them.

So what I want to do is thinking that we should do is how do we democratize this? I mean, give it out to the masses so when they have a rash, a question, it's better than any clinical symptom triager. It's better than Google. If they went to Google, they'd get a WebMD link and all the ads and everything there. So even if it hallucinates, Travis, even with hallucinations, it's better than misinformation that we see on Google or that maybe humans could miss, such as my mother, when they don't have access to care. They have to find something. So as simple as that, I guarantee you U.S. folks would use it and access it with any risk they would assume and take it. Because the benefits for that level, that workflow, very specific, can possibly outweigh some of the risk of them not seeking care or things like that. I mean, this thing has been working-

Travis Bias: That's super interesting. I think about this improving access even in the way that it would expand your mother's scope of knowledge. So maybe she's still answering the questions, but Chat GPT is helping support her in expanding what she's able to do and expanding the scope in rural areas and traditionally underserved areas. Expand The scope of the primary care physician even. Can I take care of the patient one or two more visits before I refer them to the specialist? Or how about in rural Uganda where a community health worker is maybe managing early HIV cases or people at lower level health centers in whatever country are actually handling more than they have before they have access to these tools?

David Butler: Yeah. No. I think you have definitely served in those countries before. I think I have to spend some time in Botswana, pediatric HIV there. But you're spot on. And that's immediately where my brain went when I first started doing some of this. Like US, it's a very complicated knot we've created with health care. Other countries not so much. And some of those countries that just now are getting your decent internet man that could really change their food. I mean, these things that they just have known all their lives is healthy or whatever, or not healthy. You now have real access to information, real time, to then help those folks to live a better life. And that's what ultimately technology and health care should do, right?

Travis Bias: That's the hope. So one last question for you here, and it's something that might be a bit controversial. But it seems to me, looking across, again from the industry side, I see a lot of clinical leaders, it feels like burnout was, it is and has been a buzz word. But when it comes to spending money on initiatives to support their staff, they get a little reluctant unless it's tagged to a tangible financial return on investment.

And I've seen this difficulty. We know that financially there's costs to physician turnover and their other actual financial tangible costs, but what's stopping us from investing even more for the intangible reasons? You mentioned time at home and work-life balance and other things. What are the barriers to getting meaningful and substantive investments in impacting burnout upstream and whether it's informatics tools or otherwise?

David Butler: Yeah, no. That's a solid question. And before I answer it, I'll give you a little bit about where I've spent time over the past 20 years. I've worked within, not as a consultant or anything, within four large health systems for at least three to four years each Geisinger, Texas Children's and then Bon Secours. I moved to Richmond, Virginia and Sutter Health. So I've moved my family four times for opportunity. And each time I've moved there, I find the similar infrastructures that are in health care systems.

And that is you have chief operating officers that's responsible for the day-to-day management operations type stuff. The clinics and things like that. How do they run? They provide budgets for hiring personnel and doing things like that. Then you have a CIO, chief information officer. This person typically handles all the tech type related stuff. And then you've got the CEO just running the whole ship. And I find that there is a big disconnect sometimes between the chief operating officer's needs and what the CIO has invested in. They've invested in a lot of cool tech. And the chief operating officer and sometimes the chief medical officers, they're just not technically... I think the operating model typically I've seen is they're still in a paper operating model mentally where everything's changed beneath them.

So I think that more education of that level to be quite honestly, is missing. And I think we'll have a better health care system. I'm not being disparaging towards anyone because this is hard. I mean, when you're hiring in this company and we do it this way, that's how it works. Change doesn't happen easy, even with cool technology. And so I think investing more, educating the chief operating officers, educating the chief information officers. Make sure both of their goals align to the system's mission and vision and strategy, and making sure they have tangible, whether it's... I know when I started at Sutter all these other places and executives, man, I had a tag on me. Say your responsible for quality, whether it's hospital

acquired infections, this and that. That meant whatever I do to help move that needle forward, I then get bonus. That's an incentive. If it didn't, it was not there.

And so I don't know if they're being as creative as they need to be when it comes to technology investments as incentives. I do feel like what has happened in the past 10 years, honestly, these health care systems has spent a lot of money on Epics, EHRs, and all these other technologies. So I think they're spent out, they're done. And maybe even internally, I do hear some of my colleagues say, oh my God, if the CIO asks for any more money for this Epic stuff, I'm going to scream. And I get it.

And so I think it's part of that in there. And once again, it's anecdotal. I haven't read any HFFMA articles on it or anything like that, or been to conferences where they actually know this stuff. This is just Dave Butler shooting from the hip on what I've observed overall in deep conversations I've had with colleagues of mine that are still in these roles.

Travis Bias: And you mentioned disconnects between the c-suite operators, but what about disconnects between leadership and their frontline clinicians or folks who've had recent clinical experience? Or I guess folks who have had recent enough experience to really have an empathy for that frontline worker and what they need. It seems like there's a mismatch there sometimes as well.

David Butler: Yeah, no, there is. And I remember my struggle when I was getting ready to "leave the bedside." I was like, oh no, I don't want my colleagues to think I'm selling out. I don't want them to think I'm a soup now. Okay, I see what you did, Dave. Because I'm a purist. And at Baylor, they taught us to focus. Focus on the patient not the money, not this and that. But I can definitely see how that has occurred, I'll say.

Travis Bias: Well, it's one of those that I can tell from your work, you still have a deep empathy for what the frontline physicians are dealing with. And I do as well. You're in the virtual space. I'm seeing patients through telemedicine as well as virtual first primary care where I think we can do a lot of good for a lot of patients. And that's one of the slight benefits coming out of the pandemic was it really forced us to understand what we can accomplish virtually.

And so with that, I think we should wrap up. And I do appreciate you taking the time to come speak with us today. And I hope we'll keep the conversation going as you continue to improve the experience and work environment for clinicians across the country.

David Butler: Yeah, no, that's cool. I just want to do one other thing on that one which you can edit it and put it right before this, whatever. I think what you just said was empathy. Empathy is huge. The world right now. And this is not even this podcast and not even health care. I think the world, we've been through a lot of crazy stuff the past four years. We've seen a lot. And the health care worker has seen a lot. They've had to change clothes in their garage before they go into their basement to sleep for a year and a half almost, right? So they don't affect their families. They didn't have PPE. There was no JCAHO floating. Around all these things that were normal, I think now what the doctors and nurses have witnessed was a very low in health care. And now that's what we're reconciling with now too on the national scene.

I think also from a social perspective, we all got afraid. We all had to go to our corners. And during that time, and we watched the world on fire, if you will. And now we're back. And I think it changed us in a way. Right? And I think we just have to make sure that we keep that empathy and keep that grace, though. That's the thing. And I think as long as we have that, I think we'll be okay. And so I'll wrap up with that. That's my old Dave Butler, waxing philosophical from the hip. I'm out.

Travis Bias: Empathy and grace for clinicians and for our patients. I love that. So thank you so much for taking the time. I appreciate it.