John Marchica:

Welcome to Health Care Rounds. I'm your host, John Marchica, CEO of Darwin Research Group, and faculty associate at the Arizona State University College of Health Solutions. Here we explore the vast, and rapidly evolving healthcare ecosystem, with leaders across the spectrum of healthcare delivery.

Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy in work. Please send your questions, comments, or ideas for Health Care Rounds to Podcast@DarwinResearch.com. And if you like what you hear, please don't forget to rate, and review us wherever you get your podcasts. Let's get started.

Kim Asciutto:

Today, John speaks with Dr. Robert Pearl, former CEO of the Permanente Medical Group, and former president of the Mid-Atlantic Permanente Medical Group. In these roles, he was responsible for the nationally recognized medical care of five million Kaiser Permanente members of the West and East Coasts.

Named one of Modern Healthcare's 50 most influential physician leaders, Pearl is an advocate for the power of integrated, prepaid technologically advanced, and physician led healthcare delivery. He serves as a clinical professor of plastic surgery at Stanford University School of Medicine, and is on the faculty of the Stanford Graduate School of Business. He teaches courses on strategy, and leadership, and lectures on information technology, and healthcare policy.

Pearl is the author of Mistreated: Why We Think We're Good at Healthcare, and Why We're Usually Wrong, a Washington Post bestseller that offers a roadmap for transforming American healthcare. His most recent book, Uncaring: How the Culture of Medicine Kills Doctors and Patients, was published May 2021.

John Marchica:

All right, so we're here with... I'm pleased to say, we're here with Dr. Robert Pearl, one of the rare returning guests. So, Dr. Pearl, thanks for making yourself available, and sharing your thoughts with us today, really appreciate it.

Dr. Robert Pearl:

My pleasure, and looking forward to the discussion today.

John Marchica:

Great. So, my first question for you, your last book, Mistreated, dealt, if I recall, it's been a couple years since I read it, but with many of the systemic issues in healthcare. And in many ways, to me, Uncaring, your most recent book, that actually I have here, feels like an extension of that book, and in many ways, maybe even a departure. So, I'm wondering, what motivated you to write this wonderful book, and has your thinking changed in any way since the time that you wrote Mistreated?

Dr. Robert Pearl:

Mistreated, as you say, was about the systemic problems, the for profit insurance industry, the egregious pharmaceutical pricing approach, the technology that was left over from the last century, and actually from the one before, because the most common way that doctors exchange information, as you know, is the fax machine, an 1834 invention.

So, that was what Mistreated was about. And as I went around talking to doctors, and to organizations, there was something else happening, and I say that because the idea of moving from paying for volume, to paying for value, moving from fragmentation to integrating, embracing new technology, and having a leadership structure, just seemed so obvious, then why wasn't it happening? And that led me to research this new book, Uncaring: How the Culture of Medicine Kills Doctors and Patients. And by the way, for listeners, all profits go to Doctors Without Borders, a truly wonderful charity.

This is where I discovered, or unveiled, you could say, this invisible force of the culture. And what I realized is that it's a little bit like the two snaked wrapped around the stick that is part of the caduceus. The staff of the caduceus. They are intertwined, and you can't pull one apart without influencing the other. The two go together, and I see this really much more as a second bookend, culture on one side, system on the other, not separated, fully integrated, but that's the whole, and I believe that if we're going to address the harm done to patients, and the harm done to doctors, we're going to have to involve both the system, and the culture of medicine.

John Marchica:

So that gets to my next question, which is, and I'm sure that you can speak on this in detail, the underlying theme of the book, which is that physician culture that's learned, certainly in medical school, and is reinforced as physicians practice medicine. So, talk to me a little bit more about not only this underlying theme, but where you see the problem, where the problems lie within that culture.

Dr. Robert Pearl:

Couple of things first. I want every listener who's a physician to understand that I recognize the negative consequences of the system of medicine on doctors today, and how hard physicians are working. So in no way is it anything negative, it's actually quite supportive of the work that doctors do. The second thing is that the culture is not always bad. I mean, if you look at the COVID-19, without having the repression and denial that are built into the culture, I mean, in medical school residency, were told to be tough. "Don't show emotion. Never admit weakness."

How else could you face a lethal virus, when you didn't have the protective gear you needed? When you didn't have the gowns you required, you put on garbage bags. When you didn't have the masks, you put on [inaudible 00:06:31], and when patients couldn't breathe, you had to pass a tube through their mouth into their lungs, knowing that every time they'd cough, as a tube went through their vocal cords, spewing virus in your face, how could you do those things? How could you face two patients needing... With only one respirator, and come up with the idea of putting a book on the same machine, something that hadn't been done, never even thought about?

I mean, this took tremendous courage, and the culture allow that to happen. But it's that same denial, and repression that I think are harming doctors today. And I can give you a few examples. The book obviously has a lot more than we can talk about right now. I think the first thing that I worry a lot about is the psychological damage that has happened to physicians, to nurses too, but I'm speaking about physicians today.

I talked to one doctor who lost four patients in a single day. I mean, imagine the psychological damage, and if you can't express it, and as for psychological health, PTSD is inevitable. So, one aspect of the harm that's done is through this inability to express our emotions, and to ask for help, particularly psychological help, and not have it seen as something that says, "We are weak." Or something that says that we are somehow not up to the tasks ahead.

The second part, I think, that comes out of this culture, is that what we value in medicine is often intervention, when prevention is very important. We elevate the specialist, and minimize primary care, where it really shouldn't be the opposite. We know that adding 10 primary care doctors increases quality two and a half times more than 10 specialists. And yet, in the hierarchy of medicine, where we add the values, hierarchy by the way that medical students learn first year in their training, we put the primary care physician lower, and the specialists higher, even though it makes absolutely no sense.

And what became very clear, as a combination of the external events in the United States, and COVID-19, was the systemic institutional racism in our provision of care. Something that as doctors, I don't think we acknowledged before that. We told ourselves we treat every patient the same, and yet, early in the pandemic, when there were not enough testing kits, we tested White patients twice as often as Black patients, with the same symptoms, even though the mortality was three times higher amongst the Black patients. And we gave 40% less pain medication, or you go down the list of things that we did, recommended specialty intervention and additional testing less often for Black patients.

This is built into our culture, and I think that we have to acknowledge it, and address it. I got asked in another podcast whether implicit bias, which is the underlying phenomenon, we see people who don't look like us, speak the same language, worship the same God, as not being the same as us, so we give them less empathy and sympathy. But that's somehow built into our DNA, probably from our ancestors, who had a nanosecond to decide whether that person coming over the hill was part of their tribe, or a foe aiming to kill them. That's part of being human. But once you recognize that, not acting on it, to me is racism.

Again, the culture denies it, and represses it, it doesn't see it. I think that now we have no choice but to bring it all out into the open, pull the curtain back, and let people see it. And I've been criticized, John, criticized by some people for exposing the challenges, and the problems in physician culture. And I see that, first of all, I see it just as part of the Kubler Ross stages of grief. This is the denial, and the anger that Kubler Ross described so well. But I also see it as something that we have to get past. I think the wall of silence that we built up in the past needs to come down, for us to be able to make the changes that will be better for our patients, and for ourselves.

John Marchica:

I want to take those in reverse order. How much... I've read about this sort of implicit bias, and they've done studies on this, it's been pretty well documented. As we look at COVID-19 specifically, how much of this is due to health disparities, social determinants, not having access to care? Versus, and I'm not asking you to quantify it, just to comment on it, versus that implicit bias, in the way that physicians treat white patients, versus black patients?

Dr. Robert Pearl:

It's both. In fact, the answer to almost every question about American healthcare, is what I said before, it's these systemic, and cultural issues that are intertwined. You can't separate them. So, you're absolutely right. Part of why Black patients died, or Black individuals died, two to three times more often as White individuals, was systemic issues. They had jobs that didn't allow them to stay home, and get paid by working through Zoom. They had to take buses and subways, and lived in multi generational houses.

We can go down that list that sits there. But then, how do we explain these other things that we just mentioned? It's interesting, there's just a study out this week, on hospitals across the United States, and whether they were well integrated, consistent with the local population, or whether they were, I'll say the word segregated. And they found that, particularly in places like Los Angeles, and New York,

large areas, within a few blocks of each other, you'd have one hospital that was 60% Black patients, and one that was 10%.

And what was different was the care that was provided in these different institutions. In fact, the lead author on this study talked about how there were empty beds in the White hospital, and the Black hospital was getting freezers, delivery of the body bags to take care of the people who were dying excessively.

I think this is something that we have to recognize. Is this is a systemic, or a cultural piece? It's both. It's systemic, because these hospitals are all trying to maximize their income, and a higher socio economics is likely to generate more money, and the hospital's going to have a predominately White population. Who are the admitting physicians? Are we as physicians as open to taking care of Black patients as White patients? Those are the questions I would pose.

We don't have the numbers, but any physician wants to say, "You're totally wrong, culture does not impact at all, this is being done to us by insurers, and by drug makers, and policy." I think it's hard to defend that, whether it is 10%, or 30%, of 40%. That's less of the issue, knowing that exists as doctors, who take an oath to first do no harm. When we see the harm that we're doing, I believe that we have to take action, and we've not been as aggressive at doing so, as I believe that we should be, to our patients harm, and to our harm.

John Marchica:

Well, the notion of, it's almost like the dichotomy of the victim versus the blaming mentality, or victim blame, versus the accountable mentality, right? So, it's the insurers, it's the drug companies, and maybe to some degree that, to your point, it's two heads there, the culture, and the systemic issues. It just sounds like that whiny victim mentality when you're blaming someone else, versus seeing where you're accountable.

So I said I was going in reverse order to your comments, when you talked about medical school. So, my firm studies integrated systems, that's what we do, and my research team is often... I've seen more than a few come through, who maybe they were a scribe, for a year or two, they aspire to go to medical school, we've got a couple right now that are in the process of applying. And they seem very idealistic, very driven to want to help patients, and have, in fact, one of them is going to do a public health degree before he does something in international medicine.

What is it in the culture of first year medical school, as you said, where that switch gets flipped, and people say, "Well, I'm a neurosurgeon." So, why, when people say, "Instead of going into primary care, where we're needed, or rural medicine, where we're needed, I want to be a dermatologist." "I graduated top of my class, I should be an ophthalmologist." What happens? To a lay person like myself, what happens in that culture?

Dr. Robert Pearl:

This is a great question, because we ask doctors, why are they burned out? They'll point to the fact we don't make enough money, they'll point to the fact that we have all of these bureaucratic tasks, and they'll point to the electronic health record that literally gets between them and their patients. But you're pointing out that in the first year of medical school, none of this exists yet. It doesn't impact them, and yet, we know that 27% of first year medical students are reporting depression symptoms consistent with burnout, in the first year of medical school.

And I concur with you completely, the people who go into medicine, go into it for all the right reasons. I'll say that they retain it at some level. So, now to the question you're posing, is where does it

go? This is the systemic issues, I think, sitting in play, but it's also the cultural ones. I mean, medical schools are run by doctors. I mean, there may be other administrators sitting there, but doctors have a prominent role.

John Marchica:

Of course.

Dr. Robert Pearl:

Now, what happens in first year medical school today? Let's even go back before first year medical school, the white coat ceremony. Day one of medical school, what happens? The students all come, the matriculating students come, in the audience are their parents, they get called by name, and walk on stage, a faculty member drapes a white coat over their shoulders, with one exception. The parents are physicians, they can drape the coat over their child's shoulders.

Now think about that. Why would that be? I mean, in the audience there's probably two parents who both work low paying jobs, so that their child could study hard, and become a doctor. Might be some farm workers there, who are bent over in the hot fields 14 hours a day so that their children could go on to medical school. Why shouldn't they have the same pride, the same chance to drape that coat over their children's shoulders?

And I think, it's so clearly to me, is a metaphor for what's happening, which is that the parents are seeding their culture to the faculty. It's saying, "You tell my child what's important in life, not how I raised them." It's a process equivalent in the medieval days to the bride being given away to the families of the groom, who could then instill their family's culture, rather than the one that the bride was raised within.

So, within the culture of medicine, every culture is designed to elevate status, to generate esteem, and respect. It also leads to income by the way, but income as they say, it's just part of the same process. And that's what I want listeners to be understanding. It's not an either or, it's a both. So, what do we do in the first year medical school? What is valued? What doctors are very good at, memorization, and arcane facts, that they can spew back on examinations.

Now think about that. We're the 21st century. Memorizing what's called the Krebs cycle, which we get tested on again, and again, and again, takes a lot of work, effort, memory, it's a skill set that is irrelevant in the 21st century. Every one of us carries a smartphone. The idea of memorization comes out of a time in the 20th century, when if you wanted to carry all your medical information, you have to carry a 50 pound backpack, and even then it would take you forever to find it.

Just pick up your smartphone, and type in Krebs cycle, and there it is. We're testing and teaching the wrong things. These are values left over. Culture's about the values, the beliefs, and the norms. What made us successful in the 20th century is still how we structure medical school, and if I were a first year student, I would be having the same negative reaction you described. Because I didn't come here to memorize a lot of arcane facts that I'm not going to use.

I'd like to be able to understand how to apply the information to clinical problems. I'd like to be able to take a much broader perspective. But we don't do that. We should be testing people with their cell phones available, because that's how they're going to practice. We should be testing them on the common things they're going to see, and the ability to achieve better results. We should be looking at how do they apply evidence based guidelines to achieve superior outcomes consistently, and we value anecdotal experience. This is the culture. And of course, who teaches us culture? The generation that came before.

John Marchica:

Of course.

Dr. Robert Pearl:

So, almost by definition, that culture in 2021, is going to be the culture of 1998. That's just how it works. And again, if you had high expectations of this, you thought of yourself as wanting to work hard, you're going to be dissatisfied. I'm a plastic surgeon, but I didn't do cosmetic surgery. I fix kids with birth cleft lip, and cleft palate, and I went on a dozen, 12, 14 different trips to other countries.

On these trips, people would be working 12, 14 hours a day, hot weather, there was no air conditioning. Eating beans and rice, because it was often in Central America. They'd have GI upset. They came back the happiest people I've ever seen, fulfilled, motivated, mission. And I guarantee you, take those interns, take them on a trip, they'll come back just as fulfilled.

To me, the epitome of it all was a doctor went to Liberia during the Ebola epidemic. He had to have IVs going into his arm, because it was so hot inside his suit, he was sweating, and would have passed out. I've never seen a human being happier. He came back talking about the lives that he had saved. It's beautiful, that culture, when it's well applied. It's problematic, on the other hand, what it's not.

John Marchica:

So all of those are fascinating observations. What I didn't get out of that is, when the switch goes off that says, "You know what? I'm going to get mine, and I'm going to be that specialist that's making four or five, 600,000 a year." Not that there's anything wrong with that, I'm not arguing that. But, some shift happens, is it through that brutal, 14, 15 hours a day studying to memorize these facts, that at some point, you say, you lose sight of that primary care, you lose sight of what it is that you came in for? I'm just curious.

Dr. Robert Pearl:

Yeah, well, you're absolutely right. If you ask... Well, let me start with the systemic issues. Doctors have huge debt, $200,000, $250,000 of debt, and we know, is that primary care does not pay as much as specialty. So, there is a systemic reason why. It doesn't make any sense, but it is what exists today in the economics. And of course, students recognize that.

But the interns you're talking about, probably understand that too. I mean, everyone who goes to medical school understands that they're going to incur, and yet they still go there with a lot of mission, and purpose. And that's again, why I wrote Uncaring, because I think some of that is the hierarchy. Because what they learn, in addition to the economics, is that some specialties are valued more than others. They're not the ones that they expect.

The specialties at the top are the ones who do the most complex interventions. They happen to make the most money in general, but that is who they are, and they quickly realize it. I mean, you go to medical school, you were the top of your class throughout high school and college, that's where you expect to be, and when I tell you that the star place to me is the interventional cardiologist, who unblocks coronary arteries, they're going to say, "That's who I want to be." It's true everywhere. People would like to be at the top of the game if they have the ability to get there.

And what ends up happening, and that's why, again, I think, contrary to what some physicians will say, we have it done to us by the economic system that's out there, by the number of patients to

see, by the reward we have, by the debt we incur, and we do it ourselves. Because, are you going to say, "I want to pursue a career that is low down in the hierarchy?"

So Michael Marmot looked at this question, and he found that the satisfaction of working different working groups didn't correlate with income, it had correlated with prestige, esteem, and the place in the hierarchy. And so very soon after the first year, they do a calculation of, "My score is good enough to get me to the top tier, the next tier, the next tier, the next tier."

Now, don't get me wrong, there are a few people who retain that idealism, that sense of mission and purpose, no matter what happens, and they still become primary care physicians, and are excellent. And the ones who go there because they weren't as good at memorization, or rote, they can still be better doctors. It's just that the values that are there, how we grade the system is such, that I believe that those students all want to go to the top of the hierarchy, where you'd expect. The problem is that in the culture of medicine, the values that define that hierarchy, are not the ones that correlate what's best for patient care.

John Marchica:

Yeah, yeah. One of the things, getting back to, you talked about PTSD, and dealing with COVID-19. One of the things that I struggle with, you talk about, physicians should be trained to... And I'm paraphrasing here, to be able to treat patients like family, like they treat their mother, their brothers, so on, and so forth.

But, what I wonder about, and this is my limitations, and not being a doctor, but I wonder, does that caring perspective... How much do physicians have to sort of disassociate, or compartmentalize, when you're dealing with severe illness and death day after day, after day? I mean, I imagine an oncologist dealing a lot with it. And I can't imagine being able to put yourself fully in, "I'm taking care of my mom, I'm taking care of my sister." Just this attitude, and then having these traumatic events to your psyche happen day after day. How do you balance that? How does... I just don't know, I find that to be nearly impossible.

Dr. Robert Pearl:

I think you're raising two questions. One, I'll call it the day to day question. And then number two, the tragedy of COVID. So, starting with the tragedy of COVID, the answer is you can't. Day to day, you need to have repression, and denial. In the book Uncaring, I write about a young girl with leukemia, who I spent 72 hours trying to save her life. I had to flay open her arm in order to relieve the pressure that was in there, and in the end, she dies, and I have to deal with that emotion, I have to deal with the family. It's overwhelming to me.

But the next morning, I have to go to the hospital to repair a young child with a cleft lip, and I have to give her my best. And you can do that when it happens occasionally. That's how repression denial works. But when you have four patients dying in a day, an intern was telling me that he had lost... He had started a month's service with six patients in the ICU, and they were all dead from COVID by the end. It's too much. It's too much.

Our defense mechanisms are a fine grain sieve, things slowly come through, and we survive it. That's probably the best way to say. We don't thrive when anything goes wrong, but we survive it. But when you have four, or six in a day, the whole thing breaks open, and we get overwhelmed. And that's why I'm saying, what works in one context, what works in the context of, how do I have enough repression denial to do things that are amazing?

Cut into the human body, stop the heart, and restart it, do the advanced development of cancer treatment, that early on, again, I remember my cousin who died. He'd spent weekends vomiting, in pain, and diarrhea. But the doctors first saved his life for a decade. He ultimately died again, but they advanced the field. To do these things you need to have those defense mechanisms. That's what allowed the doctors to go take care of the COVID patients early on.

But, when it starts to be again, and again, and again, and every day, you can't. You need professional help. You need to be able to talk about your feelings. You need to acknowledge this pain, and you need help getting over it, just like combatants in war, who came back from having to watch a village get blown up. We're having to take the lives of a variety of people, they need help. They did their job, but they need help recovering from it. And that's where I see us being today.

But I want to go back to the more general as well. At the end of Mistreated, I talked about my father's death. He had had a medical error that led to his demise, and the final event in a series of medical issues, was a bleed into his brain. My brother and I, who were both doctors, flew out from California to Florida, where my dad was. My sister who lives in New York was already in Florida. And when we arrived, there was my dad, he was strapped down in the bed, tied down with a breathing tube in his mouth, and a feeding tube through his nose, a line of doctors out the door.

The ENT doctor wants to do the tracheostomy. The GI doctor wants to put in a feeding tube through the abdominal skin. The neurosurgeon wants to take out a piece of his skull, to let his brain expand. My brother and I look at the X-rays, my dad's not getting better. We say, "Thank you, but no, thank you."

Those doctors were excellent physicians. My dad spent two and a half more days in that hospital. We never saw a doctor again. Some of that is systemic. There's no billing code to provide compassion, and empathy to families in their last day of life. But some of that is the culture. When a physician can't intervene, in the minds of the doctor... Not every doctor. But in the culture, the common view, "I don't have a job to be done." When I think the job to be done may be just as important as it was the day before, when care is being provided.

That's the culture of medicine, and you asked me, "How does it get taken out?" If that's the expectation, that at the time of greatest need, you're going to be not expected, in the book, I use the word desert, not just the patient, but the family, then that's the outcome, is that you start to become less sensitive. Down deep you still are, but you get stopped, you blame it on the system, but it's equally accountable from the culture.

John Marchica:

So, the last question I have for you is, you talk about the five C's of cultural change. You don't need to go through each one, but I'm wondering, where do we go from here? You point out the problem, and you offer some solutions. I haven't quite gotten there. This is a pretty long book, and I just got it a few days ago, and it's terrific, by the way. How do you affect change? How do you change the culture? Where do you start? What is something that, I'm sure a lot of physicians listen to this podcast, where would you start?

Dr. Robert Pearl:

It's hard without all five C's, because they all go together. It's not it's not pick one, versus the other. I start with the first C, which is to confront the problem. And every doctor is fully aware of the systemic issues, and they are real, and problematic, and I don't want to in any way minimize them. But if we don't look at the things that we have control over, we want to see ourselves as helpless victims, nothing's going to change.

And we've been talking about this now for how long? Five years, 10 years. No matter how loud we yell, no matter how many social media comments we make, in all caps, and exclamation points, nothing is different. Why is it going to be different in the future? I mean the quote often ascribed to Albert Einstein, he probably didn't say it, by the way, but, "Insanity is doing the same thing again, and again, and expecting to get different results." So what's going on? And I think we have to look at our contributions, and then decide to lead the way. So, that's the second thing, you have to commit to change.

And I like the visual of these two snakes, because they're so intertwined. I think you have to start changing culture, by changing reimbursement. I think as long as we're paid on a fee for service basis, we will continue to do more. But that as soon as we accept capitation, responsibility for a group of patients, with a single payment amongst a lot of doctors, now things start to evolve, including the culture of medicine.

The third C is that we connect, and we collaborate with each other, right? And that we're then able, having connected, we're able to start the change process happening. And ultimately, we get rewarded for the contributions that we do. But once we commit to that, to connecting, and then to changing how we practice, what you start to see is you value prevention, as much as intervention, because economically, it makes a lot more sense, and it's better for the patient.

You start to avoid complications from chronic disease. You start to value avoiding medical error, patient safety. You start to elevate primary care, because in an integrated, capitated model, the role of primary care becomes much more powerful than being simply a source of referral. And some specials see primary care. We don't talk about it, but it does exist today.

Telemedicine, you start to offer telemedicine. Think about that. Seven years ago, I wrote a piece on telemedicine, I was talking about the experience of Kaiser Permanente, we were doing 14 million visits a year at the time, and the rest of the world was doing less than that in total. I predicted that soon 30% of what doctors did in the office would be virtual.

Six years later, nothing was any different. And then suddenly Coronavirus hits our shores, and doctors become afraid of viral transmission to themselves, and their staff. And now it soars to 60, 70%. Yes, there's some systemic issues. The federal government eased interstate regulations, they started paying through Medicare. But what really changed was the culture that now saw this as being valuable. And I don't know what's going to happen afterwards. But, in a capitated system, you start to do that.

You create collaboration. The fourth C, between primary care and specialty care. When the patient's in the primary care's office, and there's a problem, you have a specialist who is able to do a video visit, and make the diagnosis immediately, start treatment immediately. Higher quality, greater convenience, lower cost.

We use tele-dermatology. 70% of the rashes that the primary care physician would have sent to the specialist, not the large number the primary care doctor took care of, these are the ones that would have gotten a referral, got solved in six minutes. That day, with treatment started, and yet if you read what physicians are saying about telemedicine, they're describing it as an inferior way to give care, compared to having the patient come to the doctor's office.

Some problems can't be solved through telemedicine, but the ones that can, the 30, I think probably now 40% are better cared for, without the patient having to miss work, miss school, and at a lower cost. I'll give you one last thought, I think that's really, to me was really the driver of when I decided to complete the book, and that was in December of 2019.

The federal government announced that projected increase in health care costs would be five to 6% every year for the next decade. Healthcare is 3.7 trillion. You compound interest, five to 6%, you get

to 6.2 trillion, two and a half trillion more dollars are going to get spent over the next decade on healthcare. Did you see a single Medical Association, a single specialty society say, "This is absurd. Two and a half million dollars? We can do remarkable things to help the health of people, the social determinants of health, education. I can go down the list of opportunities to use two and a half trillion dollars better than I predict we're going to do inside medicine."

When you start to ask yourself, "Why do we spend so much more than any other nation around the globe, with outcomes that lag the other 12 industrialized nations? Why are we last in longevity, and childhood mortality, and maternal mortality?" I guarantee you those $2.5 trillion could start moving us up that ladder if we used it well. And in the culture of medicine, that simply is not the approach we take, what we value, or the norms that we want to follow.

John Marchica:

Well, Dr. Robert Pearl, you're a wonderful writer, thinker, and doer, and I encourage people to read Uncaring. It's a wonderfully, not only written back, but well researched, well documented. You really put a lot of thought into this, and I appreciate your taking the time today, to appear here on Health Care Rounds, and I wish you all the success, especially as you said, because of the profits going to Doctors Without Borders. A tremendous organization. So, thank you again.

Dr. Robert Pearl:

Well, thank you, John, and thank you for a stimulating discussion and debate. And to people who read the book, I'd love to hear your thoughts. Do you agree, if you disagree, I think that the broader the audience, the more intense the conversation, the greater the likelihood that we will advance healthcare, improve the system, improve the culture, and once again, make American medicine the best in the world.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Health Care Rounds is produced and engineered by me, Kim Asciutto, theme music by John Marchica. Darwin Research Group provides advanced market intelligence, and in depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems, and the global shift toward value based care. Find us at DarwinResearch.com. See you next round.