Dr. Marty Makary: "Unaccountable: What Hospitals Won't Tell You And How Transparency Can Revolutionize Health Care"


MR. STEVE ROBERTS
11:06:53

Thanks so much for joining us. I'm Steve Roberts sitting in today for Diane Rehm. New England Journal of Medicine study concluded as many as 25 percent of all hospitalized patients will experience a preventable medical error of some kind. Other studies indicate that one in every five medications, tests and procedures are unnecessary. But most patients don't have access to data on safety and quality from individual hospitals and doctors.

MR. STEVE ROBERTS
11:07:24

In a new book, Johns Hopkins' surgeon Marty Makary reveals what hospitals won't tell you. The title of his book is "Unaccountable." And Dr. Makary is here to describe how transparency can revolutionize health care. Actually, Dr. Makary is almost here. Washington has experienced a major breakdown in its transportation system today with subways being evacuated. And he is almost here -- and here he comes. Welcome to "The Diane Rehm Show."

DR. MARTY MAKARY
11:07:59

Thank you. Good to be here.

ROBERTS
11:08:00

Delighted to have you here. You can join our conversation with Marty Makary at 1-800-433-8850. Drshow@wamu.org is our email address. Take a deep breath and welcome to "The Diane Rehm Show."

MAKARY
11:08:16

Great.

ROBERTS
11:08:17

And one of the themes of your book, Dr. Makary, is that there's just a lot of information that patients should have, deserve to have, need to have, don't get. What are hospitals not telling the rest of us?

MAKARY
11:08:35

Well, I happen to believe that the public has a right to know about the quality of their hospitals. And we looked at, for example, national registries that measure patient outcomes. And they collect patient outcomes from various hospitals around the country, track them and feed the data back to the hospitals. There are over 200 national registries. Three make their data available to the public. And most of them are actually taxpayer supported. So we collect all of this data, many times funded by the government, but the very consumers who the data are about can't see their own data. Now, you know, most people look at restaurant ratings before they go to a restaurant.

ROBERTS
11:09:20

Yeah.

MAKARY
11:09:20

But when you choose your healthcare you're essentially forced to walk in blind.

ROBERTS
11:09:26

Now, is this because the hospitals simply don't want to release it, that there are no rules requiring them to? What's the root of the problem?
MAKARY

I really think that there are not hardcore villains in this system. It's just a bad system with good people. We really haven't had these metrics for a long time. There hasn't been the demand for it. Hospitals haven't had big incentives to make the data available to the public. I think consumers, by and large, don't even know that it's out there. I mean I talk to patients and ask them sometimes, why did you choose to come to this hospital? And they say things like, the parking was easy.

ROBERTS

Every hospital knows that, too, including yours at Johns Hopkins. It's got a big parking garage right across the street.

MAKARY

Yeah.

ROBERTS

But if people saw this data, I mean you have some statistics that are pretty scary. Twenty to thirty percent of tests are unnecessary. One out of four patients harmed by medical mistakes. One hundred thousand deaths caused by medical error, if it was a stand-alone statistic, sixth leading cause of death. Those are pretty scary.

MAKARY

Yeah, and those actually are no longer opinions. Those come from specialists in the field that are looking at their own discipline. You know, the American Board of Internal Medicine just did this huge study where they asked specialists in their own field to come up with a list of five things that patients should really think twice about having when they're recommended. And they, you know, openly said there's over-treatment in the field and if you're gonna have one of these things, think twice, choose wisely, discuss it with your doctor.

MAKARY

Because increasingly now it's recognized, both among those of us on the front lines taking care of patients -- especially those of us that do a lot of second opinions, as I do as a surgeon at Johns Hopkins -- and the health policy experts, 20 to 30 percent of all medications, tests, procedures may not be necessary at all. And another 15 percent of patients are not being treated properly. They're under-treated. Now, what other industry misses the mark that often? I think if we're gonna get serious about the healthcare cost crisis, which let's face it, is burdening every family and business.

ROBERTS

Right.

MAKARY

We've got businesses saying they can't compete overseas.

ROBERTS

Sure.

MAKARY

Then I think we've got to look at the 20 to 30 percent that's now recognized to be pure waste and harmful waste.

ROBERTS

Now, in trying to diagnose the cause of this, as you say, good people operating in a bad system. And then there are elements of this system that you try to describe and isolate. And one that I found particularly interesting was what you described as the culture of silence within this system, that there are whistle-blowers, but they are not listened to. In fact, they can pay a penalty. You give some examples of that. Talk about that dimension of the problem, that there's not this internal correcting mechanism that might solve at least a part of this problem.

MAKARY

Well, when there's an aviation accident, even a minor plane accident, the black box is retrieved and the industry learns from the mistakes and all of the pilots in the country will benefit from that knowledge.

ROBERTS

Um-hum.
We don't really learn from mistakes in healthcare. We don't have systems. It's very much a hierarchical culture that's been the same...

But it's a fairly regulated industry. You have to pass board exams. You have hospital boards that presumably look at outcomes. There isn't a mechanism for accountability here?

We don't have internal reporting systems. I mean, let's face it, surgery -- my field -- medicine in general is a referral business in law, like real estate. And when you're in training, as many of us were for a dozen years, you're being evaluated. I mean, you're often being graded or you're in a situation where your reputation is everything and it makes it very difficult to speak up about things that don't look right. And quite frankly, it's role-modeled to us in medical school.

I remember a doctor who saw something that was not right in the hospital. He knew that patient had an operation he shouldn't have had. And I just noticed how he would sort of silently shake his head no, but he was also instilling a value that we don't really do anything about it. And we just haven't had the systems, the reporting systems. Now, we've got some anonymous reporting systems that are starting to really catch wind. And there's some where the hospitals can't even manage all the complaints that they get.

Most hospitals will tell you we have so many internal reports of what we call patient safety harms, that we don't know how to sift through them and how to categorize them.

Yeah, Mrs. Banks was a real tragedy. She basically had cancer which had spread all over the body. The CAT scans showed it was a classic type of cancer for which the prognosis was dismal. If the patient wanted to undergo treatment, the treatment involved taking out the uterus, the cervix, the ovaries, doing a big abdominal procedure, scraping the diaphragm. It was a very big and morbid operation that the doctors there were very interested in doing.

And it became clear to me that her input was not valued in the decision making. She had...

They were interested in doing it for financial reason?

I think they just enjoyed operating. I think that, you know, what I saw was after a good operation, a fun operation if you will, we'd high-five each other sometimes. We'd feel like that was a great case. Many times you felt like we were doing great things for people. Other times we just felt like it was a technical tour de force. It's a difficult culture to explain sometimes, but what I noticed was that her input was not really solicited.

It was almost as if her desire just to go home and die, clean up some things at home, take care of her will, spend a little time with her close friends, that was almost seen as, why would somebody do that? So I'd expressed my concern that we were really pushing something that she didn't want. They ended up getting frustrated with me because I did not get her to sign the consent form. One of the senior residents walked in -- stormed in, basically told her you need this done. You could die if you don't have it done. Of course, we're all gonna die. She was in the late stages of life anyway.

She didn't want it done. Now, I'm all for offering heroic operations. I do it every day at Johns Hopkins, but it just didn't seem right that the healthcare system as a whole wasn't telling her the truth. She ended up having horrific complications and spent the last four -- actually six weeks out of her last nine in the hospital in a very painful recovery.
And I'm interested, given this culture, how have people reacted to your book, your colleagues at Johns Hopkins?

Very positively actually. There's this hunger to be honest about our problems in healthcare. Now, there's some of the old guard that thinks I'm a traitor. Or that we should not be speaking to people outside of medicine about our problems. I've been told that directly. But by and large, doctors' organizations, nursing organizations and people that just care deeply about what they do are saying it's about time that we speak up about the problem. I mean, if medical mistakes alone were a disease, it would rank number five or sixth as the most common cause of death, using CDC estimates—depending on the estimate you use.

Now, we're all shocked to hear that because we haven't had a culture where we can speak openly and honestly about our problems in medicine, the pressures doctors are under. You know, I saw a study that showed -- last month it came out -- 42 percent of all doctors are burnt out. Yeah, we've got problems and I think doctors are hungry for fresh ideas.

More from Dr. Marty Makary. His new book is "Unaccountable: What Hospitals Won't Tell You And How Transparency Can Revolutionize Health Care." We'll get back with your calls and your questions in just a minute so stay with us.

Welcome back. I'm Steve Roberts sitting in today for Diane. My guest this hour, Dr. Marty Makary, is a surgeon at Johns Hopkins and author of a new book "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care." And Marty, we were talking about sort of all the elements of a complex system that contribute to this problem. You were talking about the culture of silence.

But one of the other things you talk about in your book is the ownership patterns of hospitals and how more and more become part of big corporations. And you have a very evocative phrase where you say that the frontline service providers, the docs, the technicians, the nurses don't feel that they own the medical culture anymore and that there's -- talk about the effect of the corporatization -- which is probably not a word but it's a concept -- in how you see it playing out in medicine.

Well, that's a great point, Steve. You know, as I go around the country talking about patient safety and quality I meet a lot of doctors. And if there's one common frustration that I hear more and more about every day in healthcare in the U.S. it's that the doctors and nurses feel that there's a growing divide between management and the frontline people doing the work. And sometimes they feel like they've got the wisdom to make the quality of medical care better and the delivery safer and the experience more enjoyable for patients. But they just feel disempowered.

They feel that their management -- they're the landlords and the frontline docs and nurses feel like the tenants. And it's sort of this landlord tenant relationship. And that, in part, I'm sure plays into the 40 plus percent of doctors in this recent study which describe feeling burnt out in their job. You know, doctors are under pressure to see more patients so they see more patients. Surgeons are under pressure to do more operations so they do more operations. Hospitals are under pressure to fill their beds so they fill their beds. Everybody's doing their job.

The problem is, as Don (word?) says, the jobs are designed wrong. The system is set up in a very dysfunctional way. We don't have metrics of performance to evaluate people. We have sheer volumes.

And that's also of course clearly a financial incentive as well. If you're a corporation -- a publicly traded corporation look at the bottom line, we see it in advertising all the time, right? People are spending a lot of money on advertising to fill their beds. And we've had many conversations on this show about how do you lower the costs and how do you change the incentives so that the incentive is to be more efficient rather than simply fill as many beds and do as many procedures and prescribe as many operations as possible.

And it's not just health care. You know, it's almost as if it's a trend in society. And it's also affected health care. I mean, you see it with teachers unions in Chicago. You see it with aviation workers. You see it in many different
industries increasingly this sense that there's a corporatization. And whereas you used to know the boss and you felt like the boss really cared about you, the boss is now at some corporate headquarters.

MAKARY

You know, last year there were a record number of hospitals acquisitions and mergers in the United States. The Federal Trade Commission's actually looking into antitrust violations. And some of us have actually been saying, are we creating institutions that are too big to fail in some of these large rural areas? I mean, St. Vince's Hospital in New York was basically the victim of bad management and collapsed. And if that happened at another place outside of New York -- in New York you've got other hospitals you can go to -- what about these hospital systems that dominate an entire state in providing the health care system.

ROBERTS

Sure. You know, another dimension that you talk a lot about in your book, Marty, is the role of patients. And you say that in the end the system is going to be improved and not by the corporations and not even by the docs but by the patients. And you talk a lot about the need to provide them with information. But as I was reading it that struck me that there are some potential problems here.

ROBERTS

One is that we're all trained to respect the judgment of doctors. We're not trained to be critical. The white coat, I mean, the aura, it's almost a priestly function. And so how do you get patients to be more critical when everything tells them you should respect the learning and the status of the doc you're dealing with?

MAKARY

Well, Steve, I appreciate what you're describing. I mean, almost every day I will meet somebody for the first time. And within seconds of meeting them they will trust me to put a knife to their skin or even tell me secrets they would never even tell their spouse instantly. And it's because of this tradition that doctors have had where they've earned the respect of their communities. But I think patients need to know that we, as a medical community, have well established research that shows that 20 to 30 percent of everything we do, medications, tests, procedures may not even be necessary and the variations in quality are marked.

MAKARY

I did some research for the book to sort of describe these wide variations and I tried hard to give success stories of things that are going well for everyone, sort of scary story. But you can look at the charts and graphs. The complication rates among well known prestigious hospitals vary by five fold. If that information were available to the public I think they could make informed decisions and our free market would be functional as opposed to what it's based on now, which is essentially billboards and parking.

ROBERTS

But it's also -- these are -- you're not buying a refrigerator or even a new car. You're dealing with life and death questions. And patients, to what extent given your experience, are they equipped to make these decisions and choose among these options in an intelligent and reasonable way? Or is -- it seems like you're asking a lot of patients to make those decisions.

MAKARY

Yeah, you know, I see all kinds of patients in my practice. I see some that are highly informed, people like yourself. From what I know about you you're very knowledgeable, you're educated, you like to do your own research. And we see people come in with stacks of Google printouts from the internet with all kinds of subcategories of disease and procedures they're asking about. And some people that, quite honestly, are just saying, look doc, you tell me what I need to do.

MAKARY

And when we measure quality on a global level, Steve, there is a broad improvement effect where the increase in the tide raises all boats. Everybody gets better. This has been shown time and time again with the American College of Surgeons Program. When you measure an outcome, feed that data back to the provider or the hospitals they're move aware of it and they do better.

ROBERTS

Well, the one variance you're seeing an example of that is what's going on in New York State where there seems to -- the New York Times just wrote an editorial about this encouraging these reforms saying with more accountability outcomes get better.

MAKARY

Yeah, it's something that makes sense. It's something that makes sense to everybody who drives through an intersection where there's a camera there. Nobody likes the camera but everybody agrees that that camera makes
almost everybody compliant with the law when they go through there.

ROBERTS

11:28:03
Let me read you some emails 'cause an awful lot of patients out there want to get into this conversation with Dr. Makary here. Here's JBS writes from Michigan, "Many people have little choice here even if they knew all the statistics. Their insurance circumscribes their choices of doctors and hospitals often very narrowly, as does the fact that in many areas there's only one big medical conglomerate to deal with."

MAKARY

11:28:29
Yeah, that's the reality of where we are today is that patients are expected to make choices but they have really almost no information and they're stuck walking in blind. And unfortunately I'd love to tell you it's getting better, but we're seeing almost a class segregation now with primary care because some docs are saying screw insurance. I'm going to set out my own shingle. You're going to pay $500 a year, $2,000 a year. You'll have my cell phone. We're going to have two-hour history and physical examination visits. And the wealthy people are doing that. And the docs that are fed up with insurance are saying, this is the way I've always wanted to practice medicine.

ROBERTS

11:29:13
Here's another email from a listener who says, "Is there a concern that ratings will discourage hospitals from taking the difficult medical cases, cherry picking only the ones where the outcomes are better?"

MAKARY

11:29:25
Absolutely. And that is a very important thing that we've got to guard as doctors. And the doctors groups have stepped up to the plate and said, if we're going to have metrics to evaluate performance at a hospital level they have to be appropriately adjusted for how complex and high risk the patients are at that hospital. Now on the flipside, although we've got the doctors groups making sure these adjustments are accurate, they're never perfect.

MAKARY

11:29:55
And, you know, when we talk to the surgeons at one hospital they'll say, well you know, this data's no good but there's an equalizing effect. If there are differences in the patient mix, why are the outcomes at say one urban large academic hospital different from another large urban academic hospital?

ROBERTS

11:30:17
That has a comparable patient load and a comparable risk factor.

MAKARY

11:30:19
That looks the same, yeah.

ROBERTS

11:30:20
Yeah. Here's a -- Rhonda writes to us, "Just recently retired from a long health care career. The major hospital system in my area here in Virginia has hospital-employed physicians do their own hospital billing. This is how the hospital incentivizes the doctors. True example, hospital list tells me that length of stay doesn't matter to his hospital. He had a patient ready to go home that day and yet because his billing was low, he was being texted, emailed, called and reminded to get his billing up to that of his colleagues. He was going to have to keep this patient in the hospital another day or two and find things to do to her -- that's a direct quote -- to get his billing up."

MAKARY

11:31:03
You know, it's sad to hear that because that happens all the time every day in America. I've got surgeons that have shown me emails from their boss that are basically beating on them to do more operations. And as long as the metric of performance is volume and not outcomes, we're going to see this get worse. And that's why we really need to push for outcomes that are accurate and that are public so that hospitals will scramble to make sure those outcomes look good. So that insurance companies will say, we're going to pay you based on your outcomes.

MAKARY

11:31:41
So Medicare and the government says, if you're going to get taxpayer dollars, it's going to be based on outcomes, not just the more you do.

ROBERTS

11:31:48
Well, it also seems to me that one of the variables here is the compensation system, that if you are paid for doing more operations there's a pretty clear incentive to do them. But if -- there's a lot of talk, as you know better than me, in the medical community these days about how do you change the compensation system. So say you give a set compensation for a medical condition or a procedure and the providers have to live within that set, then the incentive becomes to become more efficient rather than add on costs.
Talk about the compensation system right after I say, this is "The Diane Rehm Show" and I'm Steve Roberts sitting in today for Diane. Go ahead. Talk about the compensation system.

Well, first of all, compensation is never perfect. And there's no great way to come up with the most fair compensation system. But we've got hospital like Cleveland Clinic, that are saying the right thing to do is to pay doctors a flat salary and to pay them well. We're going to pay them well but we're going to give them a flat salary. And Toby Cosgrove the CEO says he believes that is the right thing to do. And we're seeing hospitals do that now.

There are a number of other systems around the country. They were talked about a lot when the Affordable Care Act was being passed as models for trying to change the compensation system.

Yeah, and we have -- we've got some hospitals that are going the other extreme and saying if we pay our doctors more on what we refer to in the business as eat what you kill -- forgive the pun.

And these consultants tour the country going to hospital executives saying, hey here's a new way to pay your doctors on a more eat-what-you-kill basis. And you will see more revenue if you switch your doctors to this plan. And they're succeeding in convincing hospitals. Now we've asked doctors in a research study that my group did, do you believe that a more eat-what-you-kill model results in more over treatment. And invariably the doctors say yes.

No, no, I -- common.

It's a term used in the law profession as well -- you're going to be able to get more cases out of your doctors. And these consultants tour the country going to hospital executives saying, hey here's a new way to pay your doctors on a more eat-what-you-kill basis. And you will see more revenue if you switch your doctors to this plan. And they're succeeding in convincing hospitals. Now we've asked doctors in a research study that my group did, do you believe that a more eat-what-you-kill model results in more over treatment. And invariably the doctors say yes.

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Sure.

I think we need to just listen to our country's doctors.

Well, let's listen to Laura here who writes to us, Dr. Makary. "A few years ago I had to have a hysterectomy. I asked the doctor, the billing person at the hospital, everyone else I came in contact with. No one could or would tell me what the procedure would cost or even give me a range. I wouldn't take my car to a mechanic who couldn't give me an estimate, but I'm expected to trust my health to this system?"

It's ironic, Steve, isn't it? We've got one-fifth of the U.S. economy in an industry where customers can't get a bid on a service, you don't know how much you paid afterwards and you can't see the track record of that service. I mean, that's one heck of a free market. You talk about walking in blind. And I think more and more patients are frustrated with the corporatization of the health care system.

When I was growing up our local hospital, which was a great hospital, Geisinger...

Well, that's one of the models you were talking about, like the Cleveland Clinic, with that kind of payment system.

It's one of the great models of health care. The head of the hospital was the head doctor. You'd see him at the supermarket. There was a problem, he was at the patient's bedside. Now if there's a problem in any U.S. hospital it's almost like you're trying to appeal a cell phone bill.

Well, also there -- you were talking about insurance and compensation systems. It seems to me that one of the unintended consequences is that unlike these other situations where a consumer is buying a car or whatever.
since so much of the cost of this purchase price is assumed by a third party that it's not only hard to get good
information, but you're also insulated from the consequences of your choices. If your insurance carrier covers it
then you have very little incentive to say well, I want the lower cost procedure because you pay no penalty for that
choice.

MAKARY
And some patients may say, I want the more expensive health care.

ROBERTS
I bet they often do 'cause they think it's the better one, right?

MAKARY
They could think it's the better one. And it's a crazy blind market where the patients don't know what they're
spending 'cause someone else is spending money for them. We as doctors don't even know how much our
services cost many times. And there's this sense of we're dealing with somebody else's money. And many people
know that the Greek financial crisis is due to early retirement, the wealthy not paying taxes. What they don't know
is that health care corruption may be one-fifth of the financial crisis in Greece. You've got a drug expenditure and a
kickback system in Greece that's completely unaccountable.

ROBERTS
Now one of the good news here is that you say the younger docs -- and how old are you today?

MAKARY
Forty.

ROBERTS
That younger docs like yourself are coming through the system with much more devotion to transparency. Talk
about that.

MAKARY
Yeah, younger people in general -- it's that generation, Steve, where they have a different mindset. They have very
little tolerance for BS in general. They have very little tolerance for secrecy. They expect transparency in every
aspect of their lives. Today's medical student is older, on average, more of a second career person. The majority
are women now. It's a different mindset and they're the ones saying, hey we need to be transparent with
everything from bedside care options to hospital outcomes.

ROBERTS
Revolutionize Health Care." We'll be back with Dr. Makary and your phone calls and more of your emails in just a
minute, so stay with us.

ROBERTS
Welcome home. I'm Steve -- welcome back. I'm Steve Roberts and you are listening to "The Diane Rehm Show."
And I'm filling in for Diane today. And my guest this hour is Marty Makary. He's a surgeon at Johns Hopkins.
And he's written a new book "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize
Health Care." And, Dr. Makary, there are a lot of folks out there who want to join this conversation. So let's start
with Stephanie in Knoxville, Md. Stephanie, welcome, you're on "The Diane Rehm Show."

STEPHANIE
Hi, thank you. I have -- my problem was with a doctor that we got through the hospital. My son who was 30 had his
first seizure, went to the emergency room and got a neurologist. Later he had a head injury. For two years that
doctor has told us he only had a subdural hematoma. And we recently found out he'd had much more extensive
damage and there's still things there that he may need surgery for in his brain.

STEPHANIE
The hospital, Meredith Cavasa (sp?) picked it up, but the times he's been in the emergency room since, they only
did CT scans instead of MRIs, so they didn't pick up that the damage was still -- there was more damage and it
was still there.

ROBERTS
Thanks for your phone call, Stephanie. A reaction, Dr. Makary.
Well, Stephanie's case unfortunately is a tragic one that I hear about almost every day. You know, we don't talk openly and honestly about medical mistakes, but when you sort of take this on as an area of interest, everybody's got a story. And it's no surprise that 30 percent of second opinions in health care are different from the first opinion. When somebody's gonna have something gigantic like a big operation electively or start a new medication that they're gonna take for the rest of their life, why not get a second opinion? There's no silver bullets in health care.

But Stephanie's story is one that I share. My grandfather died from a medical mistake. My best friend's mom had a mastectomy she didn't need. I had a research partner who lost her sister at a young age to a medication dosing error. My research partner, Peter Pronovost, lost his dad to a medical mistake. So the more we talk about it, the more we realize, yes, it is the number five cause of death in the United States.

Well, people are shocked when they hear that doctors are getting emails and text messages saying you need to do more operations by the end of the fiscal quarter in order to get your large end of year bonus. And it is a large part of the problem. Doctors don't like it actually. It's not a system they came up with. And increasingly policymakers are talking about global payment. That is you get one global payment based on the patient's outcome. You don't just get paid on the more you do.

So I think more and more we're gonna hear that conversation and we're gonna look at the successes of Cleveland Clinic. And quite frankly, the young doctors wanna work at the Cleveland Clinic or places like that where they've got flat salary, rather than this sort of pressurized eat what you kill model.

We have a number of callers, Marty, who have emailed us with one form or another the question about checklists. And let me read just one. Karen writes to us, "My boyfriend had a successful heart valve replacement, only to have the head of cardiac surgery sew a drain catheter into his heart wall requiring a second open heart surgery to remove it. Cardiac arrested, had complications. In the field I work in, which is engineering and facilities, almost every action requires a checklist, right down to changing the filter on an air conditioner, which is a three step process, I find it unconscionable that most hospitals do not use the checklist system, and in fact resist applying the checklist system. What's your opinion of checklists and how can consumers demand it?"

We actually developed checklists at Johns Hopkins. Peter Pronovost did it in the ICU and then he told me, hey, why don't you do this for surgery before operations? We implemented it. We did a study. We did -- we published a couple articles on it. And then the WHO adopted it and became the WHO checklist. And Atul Gawande popularized it in his book. And thankfully now everybody knows about the checklist. It's just no one can understand why people don't routinely use it in the same way pilots use it.

You know, we have an interesting culture in health care. It's very hierarchical. It's very traditional. We have our own values, our own vocabulary or language. We have our justice system. And we tend to only listen to ourselves. And it can be a very difficult culture to change, but the young doctors now expect to do a checklist.
And what -- and describe for listeners not familiar with the term of art. What does that really mean? How does that change procedures in the OR if you have a checklist?

Well, what we noticed was that even though there was strong evidence that patients should get antibiotics and things to prevent blood clots before an operation, many patients were not getting it. And it was sort of one of these things where we couldn't understand why we as an industry with a lot of smart people in health care cannot address the problem of leaving sponges behind and not giving patients the appropriate antibiotics and other basic systems problems. And that was really the genesis for the idea of coming up with a checklist.

Here's another email from a listener named Diane. "I'm a hospital social worker and I have seen many doctors who have difficulty looking a patient and their family in the eye and telling them the truth. I would like to see care conferences with patients and family members being required whenever there is a major change in a patient situation, a new diagnosis, say, of a chronic problem or a major change in the patient's medical condition. Talk about the fact that docs are trained in some ways to do one thing, but the whole dimension of looking the patient in the eye and dealing with the family is almost a whole other set of skills, isn't it?"

It's a completely separate set of skills and it turns out those skills, learning when not to operate, learning when not to treat are the more difficult skills than knowing when to do something. And what we've seen in health care is a culture which is just starting to crack the door open to these ideas. I think we spent one hour in medical school on talking to patients, even though we need to do it every day. You...

That's astounding.

It's astounding. Medical school is jam packed with millions of concepts. They're not hard concepts. There's just a lot of them. And the only way you learn and memorize all of them is you pair them. And you end up pairing everything as a diagnosis treatment, diagnosis treatment. You see this, you do that. And you come out with this reflex. And the reflex is so strong you don't even realize sometimes that you're losing the appropriateness.

We started a program at Johns Hopkins where families are encouraged to spend the night in the hospital with their loved one. I mean, why do we have these visiting hours ending at 8:00? I mean, it makes no sense, right? And I was speaking about this at actually a surgical conference in Africa. And I mentioned to the surgeons this new program. Well, they're all laughing. They're thinking, you Americans are sort of just discovering what we've been doing forever. We've got the families involved in the patient's medical care.


Yeah, thank you very much for taking my call. This has been a very, very interesting discussion for me. This is a passion of mine. But unfortunately I think I'm probably one of those 40 percent that's burned out and spending way too much time on a lot of what I consider to be some unnecessary things. And I really agree with your landlord, tenant analogy. That is extremely accurate. But one thing I wanted to touch on was the fact that what we're faced with as physicians, as surgeons, as caregivers is a steadily decreasing level of reimbursement, a steadily increasing overhead, both fiscal overhead, time management overhead.

And it promotes and encourages us to do more and more and more, even when we may not feel good about it. You know, I know this, I do prosthetic surgery after prostate cancer. And a lot of patients have a lot of problems. This reimbursement, it's horrible. Nobody else does it. I do it because I'm passionate about it. But I really appreciate your time and your idealism and your discussion here. Thanks very much.

Thanks, doctor. Go ahead.
MAKARY
Yeah, docs are increasingly as frustrated with the broken health care system as the patients are. And at some point there's gonna be a revolution to say, look, we need to think twice about how we're delivering care. I mean, we've got doctor's groups now saying, look, we've got to address over-treatment, burnout, drug abuse among physicians. We're looking at the Greek health care system as a driver of the Greek financial crisis.

MAKARY
And we've got to say, look, how can we set up safeguards so we can protect our doctors, value patients with dignity and make this system more efficient? Because if we don't cut the waste in healthcare, there's no way we're going to handle the huge, huge number of elderly patients that are about to enter the system and the future diseases that are coming from obesity, because those come 10 or 20 years after somebody becomes obese. The joint problems, the heart disease, the dialysis...

ROBERTS
Diabetes.

MAKARY
...and diabetes.

ROBERTS
Right. Gary in Dallas, Texas, welcome to "The Diane Rehm Show." What's on your mind this morning?

GARY
Oh, thank you. Just the bottom line is we don't have a health care system in this country. We have a sick care system. And until the system changes where we have disincentives for physicians, as well as hospitals acting like they're a hotel, the more people that are in it, the more money we make, and having doctors doing more procedures, and I empathize with this physician who was just on the call a moment ago, and with prescription drugs which are sold in every other country at a fraction of what they are charged here in this country, the whole system has to change. And it has to change universally for us to have an effective care system.

GARY
We have to focus on outcomes and results and taking care of people before they become diabetic and all the other diseases that come from it. And it's a whole mindset about the population educating ourselves about eating and health and exercise. It goes all the way down to the education system. Everything has to change in order for the health care system to eventually change.

GARY
And the doctors and the hospitals have to buy in to the fact that we need to treat patients only when they are sick and not to get into the hospitals. It has to be their incentive. They should be thinking that process of remuneration instead of E&M coding, the way they get paid for more dollars for an E&M visit that takes 15 minutes and they charge for a 45 minute visit when they only saw them for 5 minutes.

ROBERTS
Gary, thank you very much for your phone call. I'm Steve Roberts. And you're listening to "The Diane Rehm Show." This whole question that several callers have brought up that relate to the compensation system, but also the role of doctors in general. And are there ways in which time can be used more efficiently? Introduce physician assistants, nurse practitioners to deal with well problems as opposed to sick problems, as Gary was saying, that we're a system that doesn't look enough at preventive care.

ROBERTS
And how do you provide access in a low cost way to prevent the kind of obesity -- to take perhaps the single best example of all of them, of obesity and diabetes and other chronic care? Talk about it from the point of view of physician. Is that part of what needs to change in terms of how services are delivered and by who they're delivered?

MAKARY
Absolutely. I've met doctors that approach companies and say, let us work on the health of your employees. And you will see a massive reduction. And, you know, sometimes they do things that are general good health things, diet and exercise. Sometimes they focus on what they call the high utilizers, those with serious risk for really being frequent flyers in the health care system. And when they focus on patients at high risk for health complications, they see tremendous, tremendous benefits, both in terms of patient health and cost savings.
And of course, you know, I remember a few years ago I was moderating a conference where one of the executives of AOL, then a major figure in the internet universe, and a lot of their employees were younger and a lot of them were women of child bearing age. And they said every dollar we spend on prenatal care saves us so much money down the line. If we can prevent one disaster, it saves such an enormous amount of money. They were spending a lot of money on getting people into the system early because it wasn't just a question of generosity or humanity, it was a question of the bottom line.

MAKARY

You know, when I interviewed for medical school, Steve, I remember saying that one of the reasons I wanted to be a doctor was to do foreign medical missions work. And it turns out most people interviewing for medical school say they want to do some overseas charitable medical work. But very few ever will. And why is that? Well, we take good people and we put them in a bad system where the incentives are misaligned and we've got people like these last two callers that say, yeah, 40 percent of doctors are burnout, that's me.

MAKARY

And when you're burnout, you're gonna do more sloppy medicine, expensive medicine, wasteful medicine and unnecessary care. We've got plastic surgeons now that when they sit for their board exam, they have to do report the billing codes for certain procedures. It's a part of getting your board certification to be a plastic surgeon is to memorize the billing codes.

ROBERTS

Let's end on a positive note here. You say -- you point out in your book that there are some good stories, there are people who are really working hard to improve the system. Give us a good example of the hopeful side of this, reexamination that's coming from -- at least in part from younger docs wanting to practice their profession in a different way.

MAKARY

You know, I remember touring the Mayo Clinic, visiting a friend of mine and every few operating rooms there was this giant lounge with food and ice cream and desks and work areas and TVs and couches. And I said, oh, my gosh, you've got all these, you know, leisure rooms here to relax and work. It's almost as if doctors designed this place. And he said they did. And increasingly doctors are taking control of these areas of health care where they're just fed up. We've got this active surgeon who's head of the Cleveland Clinic saying, this is the way we're gonna do it, we're gonna pay everybody with a flat salary 'cause it's the right thing to do.

MAKARY

We've got the Society of Thoracic Surgeons saying, we're gonna measure outcomes in a way that we believe appropriately accounts for everything. And we've partnered with Consumer Reports to make that information available to patients. And once patients start figuring out where all these things are, and different app companies learn how to extract it from all the corners on the web where they live, patients are really gonna start having great information.

ROBERTS

Good way to end the conversation. Fascinating. With Marty Makary, he's a surgeon at Johns Hopkins. His new book "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care." Marty Makary, thanks so much for being with us on "The Diane Rehm Show." I'm Steve Roberts sitting in today for Diane. And thanks to all of you out there for your calls, your questions and being such a loyal audience. Have a good day.

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