Peter G. Peterson Fiscal Summit 2017: A Conversation with Atul Gawande

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Interview With Dr. atul Gawande

Interviewer: michael peterson

Atul Gawande, MD, MPH, surgeon, writer and public health researcher joined Michael Peterson for a conversation about how healthcare delivery reform can help reduce costs and improve quality of care.

This interview with **Atul Gawande**, MD, MPH was conducted by **Michael A. Peterson**, President and Chief Executive Officer, Peter G. Peterson Foundation, as part of the [**2017 Fiscal Summit**](http://www.pgpf.org/what-we-are-doing/fiscal-summit).

\* \* \*BEGIN INTERVIEW\* \* \*

ANNOUNCER: Ladies and gentlemen, please welcome Dr. Atul Gawande of Ariadne Labs, and our moderator, Michael Peterson. (APPLAUSE)

MICHAEL PETERSON: Thank you. Well, it's great to have elected officials come present at your conference. But once in a while they actually have to take votes. And so Steny Hoyer, and Kevin Brady are currently voting. So we have a few extra minutes. And Dr. Gawande was-- was-- was prompt and early. And so we thought we'd add-- about ten to 15 minutes of additional discussion with Dr. Gawande about healthcare delivery. So as many of you know, Dr. Gawande is involved in a variety of things.

He's a surgeon. He's a writer for *The New Yorker*. He's on the-- he's a professor at Harvard Medical School, and runs something called Ariande Labs. So, Dr. Gawande, why don't we start-- talking about your recent book, *Being Mortal*. As you know about a third of Medicare is spent in the last year of life. So it's a very important part of the fiscal side.

But these are real issues people deal with in terms of what-- what decisions they make, how they approach the process. You've spent quite a bit of time thinking, and looking into this issue. What-- what did you come up with-- as you looked further into it?

DR. ATUL GAWANDE: Yeah, so the way we usually think about this problem is so it's about 25% in the last year of life. And-- the majority of that is in the last couple months of life. And so we classically will say, "Look. We-- there is-- low value-- high suffering associated with that. And-- if we could just do something about that we could fix a whole lot of what's going on in Medicare."

And so the only problem is knowing when your last month of life really is. (LAUGHTER) Right? There's-- the-- the way we therefore reduce the debate in Washington is, "Will you get the $80,000 drug that will give you maybe 12 weeks more of life, or do we take that away from you?" And that actually is the wrong discussion. And the way that-- we came to understand what the issue is. I mean, I always think about it as a surgeon. Right?

These are some of the most uncomfortable discussion I have as a cancer surgeon is, "Should I be doing an operation that is unlikely to benefit you?" But I don't have 100% certainty that it's going to. And basically the thing that we learned is-- it comes out of a research trial at the Mass General, but replicated many other places and ways, that took patients with stage four lung cancer, and said, "We're gonna give these people-- half of them usual oncology care. And the other half will get-- will get a oncologist, but also early palliative care visits from the very beginning of discussions."

The result of doing that was that that group who got the palliative care discussions ended up-- with several things happening. Number one, they were less likely to-- die in the hospital, less likely to die in the ICU. They stopped chemotherapy far earlier. They had about a third lower total costs of care. They had-- they had, like, 80% less likely to have chemotherapy in the last-- few weeks of life.

They started hospice sooner. They had more time at home, higher quality of life with-- less suffering. And the kicker was they lived 25% longer. So the answer as in there. The reality is we're making many bad choices towards the end of life where we are failing to have planning that says when-- that allows us to come to a decision that we're actually causing more harm than good.

And coming to decisions that allow us to make those choices where you really can't end up with ha-- better quality of care, lower cost. So-- a lot of the work we've been doing is about creating that at larger scale. Happy to talk about that.

PETERSON: Yeah. So at the Peterson Center on Healthcare what our mission is, is to go out, and find, and validate high performance healthcare solutions where you can get better outcomes at lower cost. The latter stage is to replicate those, and spread, and scale them across the country. There's an old saying that it takes 17 years for any new technologies to emerge in the healthcare system in this country. So what approaches are you using to speed up, and s-- and scale some of these solutions?

GAWANDE: Yeah. So-- if the answer was that everybody needs a palliative care clinician right from the begin-- you know, first of all palliative care clinicians are in short supply. The-- they only reach maybe 5% of people who have a cancer diagnosis. And that's only a quarter of the way that we die. Right? So you can't scale that.

What I ended up doing in the course of the book was interviewing many of the people in the palliative care world about what is it that they're doing that's different from what other doctors do. And my way of going at it was saying, "When I next have my conversation with a patient, what should I be doing differently? What is my checklist (LAUGH) for-- for my conversation?"

And the short answer was that what they were doing differently, it wasn't that they were prescribing different drugs, it wasn't that they were-- having a different plan, what they were doing was they recognized that their role was to ask people, and have conversations about what your actual goals of care are.

And this was where the insight really comes out, which is that people have priorities in their life besides just living longer. When we-- the most important way to learn what those priorities are is to ask. And we don't ask. When we don't ask, then you're more likely to have your care not match what your priorities are for the quality of li-- of your life. And the result is tremendous suffering, as well as tremendous cost.

So what we have just been-- testing in Massachusetts-- and now have deployed at a relatively large scale, and are learning to take it to larger scale, was we did a randomized trial at the Dana-Farber Cancer Institute where the clinicians agreed to let us-- do an experiment on them. Half of the clinicians, non-palliative care clinicians, these are oncologists, were-- trained in how to have a palliative care kind of conversation.

And that conversation is, one, not the usual way we talk in medicine, which is-- "Here are the options, A, B, and C. Here are the facts. Now you tell me what you want." And invariably-- people then don't know what to do. And so instead this conversation is, "You tell me your goals. And then I will give you a recommendation for what meet those goals." It's tricky to get people's goals.

And so you ask questions like, "What-- what is your understanding of where you are with your health, or your illness at this time? What are you willing to go through, and not willing to go through for the sake of more time? What are you fears and goals if your health worsens? What's the minimum quality of life you'd find acceptable? And have you told your family, and your healthcare proxy, your answers to these questions?"

The result was we were able to replicate the results that were just done the-- by the palliative care clinicians. So we have been able to demonstrate that the group who-- had these clinicians ended up having-- several things happen, less suffering. They had more, earlier, and better conversations about their goals. They had-- same survival, and lower costs.

So now-- in Massachusetts we're-- we've made a coalition with-- a bipartisan coalition involving-- people across the political spectrum from the Republican governor, to-- Democratic policymakers, but also, critically, plenty outside the government as well involving the healthcare systems, the insurers in the state, and a few others. The building blocks are, number one, that we ask people to name your healthcare proxy. Who is gonna make decisions when you can't?

Most of us will come to the end of life with someone else needing to make that decision. And when we don't you get bad care. So name who your proxy is, and have a discussion with them about your goals. Second is that we are-- we're seeing that the-- important thing is to really disconnect the idea that getting palliative care in a hospice setting is something that you currently have to give up curative care, give up surgery, chemotherapy, things like that before you get it.

And we've got nearly all of the insurers in the state now to have agreed that hospice care would be covered-- without your having to give up curative care, which gets people starting on these conversations, and into care earlier around the quality of life. And then the third component is really getting agreement that we are training clinicians in how to have better conversation. 'Cause most of us, I certainly didn't, do not do it very well. And so we've got agreement of all the medical schools in the state to being teaching these basic skills.

PETERSON: So what has been the der-- the response of doctors to this? In-- in a lot of the research we've done we see solutions that are better for the patient, they have better health outcome, they're better for the docs and the other clinicians, and they're lower cost.

GAWANDE: Right.

PETERSON: So in this sphere what did you have to do to get into the doctors? And what was their reaction to this? What's-- I mean, this is-- these are tough conversations as you said. And if they've been practicing for a long time, and not having them, what kinda transition do they need to make?

GAWANDE: There's all kinds of-- reasons why both doctors and patients have anxiety about these-- taking this path. The doctors have anxiety, "I don't have the time to do this. Takes too long. No one's paying me to do this. But I do get paid for the chemotherapy, and the operation, and everything else." Right? So, you know, all of those incentives are pointed in the wrong direction.

Second is tremendous just plain anxiety in truth about being skilled at these conversations. End of life conversations for most of us, it certainly was for me, is-- an aversive experience. It makes you feel like you are on the opposite side from the patient, and arguing with them about what you're gonna take away.

And learning the-- the-- to-- to have the conversation in a way that both as families, and as clinicians, what we're not asking is, "What-- what will you give up?" What we're asking is, "What are we fighting for? Are we fighting for your quality of life? And what is the quality of life you absolutely do not wanna sacrifice? What are your priorities?" And we make sure we adhere to them.

The experiences in the trials that we've done is that the clinicians are-- more than 90%-- find-- find that-- that once they've had the training they end up adopting the approaches that we've got, because it actually puts them on the same side of the ta-- of the table with the patient where we're together setting the goals. And then the insurers, and the state are very much on the same side saying, "Look. This is about giving people control, and choices."

One of the things in our polling, the least likely group to have a conversation with their family, or their healthcare team, about what their goals are for their care are-- high school only educated, instead of college educated, men more than women-- and minorities. And that is the vulnerable population in particular.

And the language of going in, and being able to say, to clinicians and to patients, that this is about control, has been-- what's resonating for people. And so we're learning how do you take that to larger scale. And then, you know, we have partnerships with the largest health system in Texas, with-- Blue Cross/Blue Shield across Massachusetts, to figure out how to drive this to scale. And on the Hill it's discussions-- that start with-- really starting to-- incentivize people to get their healthcare proxy, and to-- decouple hospice and palliative choices from whether you have to give up care.

PETERSON: Most people who get in this issue face criticism-- of the death panel issue, and talking about that. What-- so for politicians, or policymakers looking to get into this, and stimulate a conversation, what is the best way to avoid the demagoguery against it?

GAWANDE: This was a huge reason that I wrote the book-- when I did. It was in the middle of the-- death panel-- debate that I first wrote the piece for *The New Yorker*, and then turned it into a much deeper investigation. And I think we've come a long way in the three years during that time.

And I think a sign of it was that during this last election the charge that paying clinicians to have these conversations is a death panel was floated several times. And it had no traction. That this is successfully penetrated enough that understanding that this set of conversations, this cultural reshaping of our choices in healthcare, and-- supporting them with our policies is neither, by Democrats nor Republicans-- something that people wanna have happen.

We've all-- so what we see right now is-- 30% of the population has an experience this year with-- a loved one, someone close to them, who's died. The rating on the quality of that care is terrible. 50% find the-- the care is poor, fair, or mediocre.

PETERSON: This is judged by the family member, or--

GAWANDE: Judged by the family members afterwards. And-- and when people have had these conversations it goes from that kind of poor care, to-- more than 85% reporting the they have-- have had excellent, or very good care. So the experience of the care, and people know this more and more-- 50% of the population just in the last decade have-- now experienced-- having hospice care-- at the end of life.

And so it's become something that was a fringe, rare thing, even as recently as a decade ago it was less than 20%, most of us died in institutions, and most of us experienced that along the way, to where this is-- a normal part of our day-- our experience. We all cot-- got exposure. So I think that the political winds have shifted here.

PETERSON: Right. One of the successes you've had-- in scaling solutions is on the surgical checklist. the penetration of that not only in the United States, but around the world, has been very successful. Tell us a little bit about how you came up with that, and some of the scaling solutions that you adopted for that approach.

GAWANDE: Yeah. So-- again I-- it was tact-- you know, so a lot of the work that we do, I'm known for my writing probably more than (LAUGH) anything, but on the side I've been running large scale experiments for about a decade now-- devising solutions that get to better, more efficient, lower cost, higher quality healthcare delivery.

And the first place we started was in my field, in surgery. And-- what we recognized is there's a 250% difference in the quality of your care, and your survival, depending on who you go to for your care. And the highest quality results were not the most expensive results. That's-- that's-- that's saying something really important, right?

Mitch Landrieu over (LAUGH) there was saying earlier like, "Less is always less, and more is always more." This is genuinely one of those situations where we have-- the highest cost care has no correlation with the quality of the care. So then capturing what the positive deviants are doing that get you higher cost care-- higher-- higher value care, higher outcomes with lower cost, was the critical component of this.

And so we studied with engineers. We got a Boeing safety engineer literally comes with us in the operating rooms, and examine what the high quality teams were really doing, and that-- and turned it into a checklist for surgical care. And most of it was about team communications, having a huddle before the anesthesiologist administers anesthesia, before the surgeon makes their incision, and before the patient leaves the room, to agree on, what are the goals of the care.

What are we all doing? What equipment are we gonna use? How much blood loss do we need to be prepared for? How long with the-- will this case take? And walking through each of those steps. The result was when we tested in eight cities around the world was a 50% reduction in complications, and deaths. It was a massive-- improvement. We then deployed it here in the United States. And our most recent work has been for the last five years with the state of South Carolina, working with every hospital in the state.

So we've had this experiment going on since we published in 2009 about the value of this work. And-- and the cost side is every complication is a $70,000 added cost to your operation. You go from a $17,000 operation to adding $70,000 to that. The screwiness (SIC) of our system is when you have a complication it is a $58,000 profit for the hospital.

So you have a wrong incentives pointed in-- in-- in-- in the ways-- in this-- way here. We've had various reactions then in how people go about doing it. In Canada they mandated that you adopt the checklist. (LAUGH) They passed a law. You gotta do it. The result was no reduction in mortality. And what you saw was nurses sitting in corners, filling out paperwork, saying, "We did the checklist," but nothing actually changing. In South--

PETERSON: They weren't actually doing it, or it--

GAWANDE: They weren't-- they weren't-- and so the surgeons --you know, surgeons, we don't necessarily like having to do a checklist, right? And the-- the critical thing is getting surgeons to really embrace it, and make it part of your care. And you can't just do that by passing a law. So-- Washington state did a pay for performance program. They paid the hospitals to do it.

And, you know, what we measured was about a 40% adoption rate. But 60% really didn't follow through. South Carolina, it's a red state, so they did not wanna regulate. And they didn't have the money to do a pay for performance program. So we ended up with workin' with the private insurers, the State Hospital Association, and created a voluntary program.

And in the voluntary program we walked all of the hospitals through an adoption program where you mainly work to win all of your staff over to doing this work. And it worked. Getting-- the hospitals for about 40% of the state to follow through. And they-- and we proved it lowered-- we just proved two weeks ago, lowered the death rates across South Carolina by 22%. As many lives saved as die in car accidents from that.

But it did not reach the other 60%. Scotland we rolled it out combining the approaches. So it was mandated-- in Scotland as something the hospitals had to do. But they put in funds to provide support training following our approach. And they lowered the death rate 27% for the whole-- for the whole country-- saved-- now three times as many lives as died in car accidents, and-- and with a cost savings along the way.

PETERSON: Amazing. Well, Dr. Gawande, we're so thrilled that you're here today. Thank you for filling up-- a few extra minutes. (LAUGH) It's bonus time with Dr. Gawande is always appreciated.

GAWANDE: Many thanks, Michael.

PETERSON: And-- we'll have you back in a few minutes for a br-- wider discussion with the other panelists.

GAWANDE: Looking forward to the congressional discussion here too.

PETERSON: Okay. Thank you. (APPLAUSE)

\* \* \*END OF INTERVIEW\* \* \*