Fixing Healthcare Podcast Transcript

Interview with Leana Wen

Jeremy Corr: Hello and welcome to the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of the Permanente Group, the nation's largest physician group. He is currently a contributor at Forbes, a professor at both the Stanford University School of Medicine and Business and author of the best-selling book Mistreated: Why We Think We're Getting Good Healthcare -- and Why We're Usually Wrong. Together, we also host the bi-weekly Coronavirus, The Truth podcast.

Robert Pearl: Hello everyone and welcome to the fourth episode of season five. This season is focused on the culture of medicine and how it both supports doctors and nurses in providing superb medical care in the most difficult of circumstances, such as during the current coronavirus pandemic, but how it also leads them to inflict harm on themselves and their patients. If you want more information on the culture of healthcare, you can find links to articles and other podcasts on the subject on my website, RobertPearlMD.com.

Jeremy Corr: Our guest today is Dr. Leana Wen. Dr. Wen is an emergency physician, a public health professor at George Washington University, and she's a contributing columnist for Washington Post and on-air commentator for CNN as a medical analyst. Previously, she served as Baltimore's health commissioner.

Robert Pearl: Welcome Leana. It's great to have you on our Fixing Healthcare podcast.

Leana Wen: I'm thrilled to join you. Thanks so much.

Robert Pearl: This season is about the culture of medicine, the values, beliefs, and norms we learned in our training, follow throughout our clinical practice, and share with our colleagues. In your various roles from ER physician to public health professor, to Baltimore's health commissioner, you've confronted the systemic issues of American medicine, from lack of coverage, to a lack of a comprehensive electronic health record, to the negative consequences of multiple socioeconomic challenges. Today, I'd like you to focus on the culture of medicine, both the remarkable courage it gave doctors, nurses, and others in healthcare, allowing them to treat people with COVID despite having inadequate personal protection, and the ways it harms both doctors and patients.

Robert Pearl: Let me start with a few beliefs that most doctors as individuals profess and see if you agree to what we say we do is what happens in practice. We believe that as individual physicians, we treat all patients the same, is that what we do, and if not, can you give us some examples?

Leana Wen: Well, first of all, I appreciate your inviting me to be part of this discussion. I think it's such an important one. And so many issues that the public has now seen from COVID-19 are not new issues, but they are getting new awareness and renewed awareness and I think it's so important. And so appreciate your bringing many of these types of issues to light. We do in medicine, of course, we need to uphold our oath. And part of that oath is treating everyone with the same dignity and humanity, no matter who they are, what they look like, whether they're able to pay. We treat everyone with the humanity that we would want to be treated with ourselves.

Leana Wen: That does not mean of course, that everybody gets exactly the same treatment to the sense that people should be getting the treatment that's tailored to them. There should always be an accounting of their health conditions and their medical issues, but also there needs to be understanding of people's values and informed decision-making hinges on being able to treat individuals as exactly that, as individuals tailored to the conditions to what they believe is most important to them. Now, of course, we need to have standards. In medicine, there are certainly issues that are black and white, but a lot of other things that are in this gray zone, and within this gray zone is where the decision-making must be made in concert with patients in a way that furthers our respect for them as individuals.

Robert Pearl: We tell ourselves that we save a life at any cost, and yet we're seeing a disproportionate number of people dying from chronic disease, much of which could have been prevented. How do you see the physician culture when it comes to our embracing intervention and seemingly often ignoring prevention?

Leana Wen: It's a really important point. And again, one that we are seeing in COVID-19. It's often been said that public health works when it's invisible, by definition, that you don't see the face of public health, because we have been successful when we have prevented something bad from occurring. But then as a result, we don't focus on prevention. Public health and prevention efforts are the first on the chopping block whenever we're discussing budget issues. They are certainly not front of mind for many people. And one could argue, that's how we got into the mess up we are today with this public health catastrophe, because we did not invest in public health infrastructure. You can see the same thing when applied to chronic disease prevention as well, that we also are not prioritizing thinking about the long-term consequences of our short-term actions, and are not focused on this largely in our society, as well as on the individual doctor patient level too.

Leana Wen: This is not a virus that is doing the discriminating, but it's our systems that are. So we have a city like my city here in Baltimore, where one in three African-Americans live in a food desert compared to one in 12 whites. So is it any surprise when we also see that African-Americans are disproportionately affected by heart disease, diabetes, obesity, the same issues that then predispose to more severe disease from COVID-19 and death and hospitalizations from COVID-19. So all of that is traced then to these social

determinants of health that we in public health understand so well, but I think are just not reflected in the general understanding, including in medicine. And I hope that if there's anything that COVID has taught us, it's the attention to these long-term issues, including, as you mentioned Robbie, to prevention that have just gotten short tripped all along.

Robert Pearl: Let me expand that, Leana. I remember reading a survey about asking doctors and patients about the most pressing healthcare problems that existed. The top three for patients once using the safety net clinics, many of which you were a champion for, the three top things on their list was housing, food and heating. None of these made the doctor's list, and conversely, none of what doctors placed in their top three made the highest five for these patients. What can we do to bridge that gap?

Leana Wen: That's such a good point. And I think that's right, there is a disconnect that exists. And I think that disconnect exists in part because of how our healthcare system is structured. I remember back in my medical training, being told by attendings that there are certain things that we just should not be asking because, and so the thinking goes, what are you going to do if you get an answer to which you cannot then help that patient? For example, what if we find that a child is coming in all the time for asthma attacks but the problem is that he is living in a house that has vacants all around their apartment, and there's nothing that you can do about the mold in other people's apartments? And that's actually what's triggering his asthma attacks. Well, at the same time, if that's what's making him ill, isn't it also our responsibility as physicians and as healthcare workers to tackle those issues as well, because that's ultimately the root of his illness? Otherwise, we're only addressing the symptoms and not the cause.

Leana Wen: And so I think some of it is the awareness that for us, as clinicians, that there are these underlying issues that are also leading to illness. There also then needs to be a willingness to open Pandora's box, so to speak and be willing to get answers that are very uncomfortable for us, and to also realize that we may not be able to resolve these issues in the clinic or in the ER or in whatever setting we're in that day, but that doesn't mean that we should turn a blind eye to these issues. We should still understand what is going on in our patient's lives, do our best to address them, understanding that we can't do it all, but that if we do not seek to understand what's happening in our patients' lives, then we're certainly not going to be successful at addressing our patient's most pressing health needs.

Robert Pearl: As physicians we say that we should never modify our recommendations based upon cost, that cost is an issue for the insurance companies. Does that still make sense in the current healthcare world?

Leana Wen: That's a really interesting point. And I know that you have done a lot of research and writing and analysis on this. In my view, we need to do what's best for our patients, recognizing that we do not live in a perfect world. In an ideal world, we

should not be rationing care. In an ideal world, we should not be making decisions based on costs, but based on science and evidence. But we don't live in that ideal world. I don't want to be prescribing my patients a medicine for their high blood pressure that they're never going to take simply because their insurance doesn't cover it. Even if it's the best medication for them, if they literally are not going to be able to take it, then it's not going to have much impact on them either.

Leana Wen: I also think that it's demoralizing, it's very difficult when we tell our patients to do things like exercise or eat fresh food, but they live in a place where they can't access fresh produce. And so we need to come up with recommendations that people can actually do. And so to the issue of cost, I do think it's important to have a discussion with our patients about cost because they live in the real world. And it is really important for us to actually meet people where they are to take into account people's everyday needs.

Robert Pearl: You know, Leana, in the 20th century, the scope of medical practice was clear. It was the one patient in the exam room. Now the boundaries are becoming relatively amorphous. Where do you believe these boundaries should end for doctors in areas such as gun violence and gun control, climate, immigration, and a myriad of other social issues that increasingly are permeating our specialties?

Leana Wen: That's another interesting question. And actually my views on this have evolved over time. And I'll explain. When I was a medical student, I was very involved in the American Medical Student Association. I was on the board of directors. I also took a year off from medical school to serve as the AMSA national president full-time I worked in D.C. And at that time I was trying to press the rest of the medical profession to this understanding that there is no such thing as staying in our lane, that because our patients are coming to us with all these complex needs, and because we see that all these issues are intricately intertwined with health, that we need to be advocates for our patients on all these issues. Of course, over time, I've seen the limitations of this kind of view and in a couple of ways. One is that if everything is a priority, nothing is a priority.

Leana Wen: And so I think it is important for us as individuals to figure out what are the issues that are the most important to us. And I think there's another issue too, which is there are some people who, for whatever reason, may not be comfortable with public advocacy, as in they may not want to be posting on their social media, they may not want to be in the national media, they may not want to be for any number of reasons, right? Maybe they work for an organization that's very conservative, I don't mean in terms of partisanship, but just in terms of not wanting their physicians to be out front on these issues. Maybe they are worried about their personal safety and the safety of their family, and don't want to be out front on these issues, or maybe they just have a different view on this. Maybe they will be asking patients these questions one-on-one for example, about whether there are far arms in their house in order to

talk about safety when it comes to suicide risk and to risk for their children, but don't want to be out front talking about gun violence as a health issue.

Leana Wen: I mean, I think that we need to have tolerance of people, including clinicians in this case, wherever it is that they are. If they want to be public advocates on these issues, I urge people to choose the issues that are the most important to them because you can't really be an advocate on every single issue. But I also think that for those individuals who are not able to do that advocacy, we should also respect that too, because people need to make the best decisions for themselves when it comes to where they can do the most amount of good. And for some people it's going to be in the public sphere, for many others it's going to be making a difference one-on-one with patients and in communities. And all of those are very valid and very valuable ways for being a physician who is serving the public's good.

Robert Pearl: Leana, both in your work at George Washington in DC and your leadership in Baltimore, you've seen the challenges our nation faces in providing excellent medical care to Black patients. I'm particularly impressed by the three times mortality in African-American women during childbirth or the studies that found that if a Black and a white patient come into the EG with the same exact COVID symptoms, the testing is more often done for the white patient than for the Black patient. We have a shortage of African-American physicians in the United States, how can we best address that?

Leana Wen: Again, such critical issues, and I'm really glad that you raised the issue of Black maternal mortality. Already, it's a major problem that we have women today who are dying in childbirth at higher rates than our mothers were. We are the only developed nation for which that's the case, or that maternal mortality has actually gone up rather than down. Infant mortality also a major issue as well. Also, we see huge disparities in infant mortality, as well as maternal mortality based on race, based on income, based on zip code that are again, illustrate that it is our systems that are doing the discriminating in this case, and we need to be attentive to the structural racism and inequities that really permeate healthcare, as well as other systems in our society.

Leana Wen: When it comes to having a more diverse workforce, we need to be looking at pipeline. We need to be attentive to the programs that start early on in high school and even before, that are recruiting future healthcare workers and providing career paths and mentors, and also looking at issues like student loans that may be really big barriers and dissuading people from pursuing certain professions. And so I think these are complex issues, but I think being attentive to the fact that these issues exist in the first place, but also looking at the programs that are already working and then scaling up these programs for specifically recruiting African-American doctors, and physician assistants, and nurse practitioners, and others will be really critical in these efforts.

Robert Pearl: Bridging from that theme, as a woman in healthcare and a mentor to many medical students and residents, how do you see sexism in medicine and what should we do about it?

Leana Wen: Well, I mean, racism and sexism in medicine have long existed. I think there has been a lot more focus on this then even when I first started medical school in 2001. And so I think we are certainly headed in the right direction. I don't know that I have a great answer here for you, Robbie, because I think that awareness and being able to talk about these issues is an important first step. I also would just caution us to approach these issues with kindness and empathy, recognizing that so much is ingrained in our culture. So I really have a problem with this kind of call-out culture where you're calling people out and I of course understand the need for accountability. And when there are blatant examples of harassment and other illegal behavior, we should have consequences, there should be consequences to that.

Leana Wen: But I also think in many cases they are examples of people just not doing the right thing because they don't know the right thing to do. And I'm not saying that we should be excusing these behaviors necessarily, but rather than we should approach individuals with compassion and empathy and understand that they are also in the position that they're in because of lack of role models and good teaching. And so we should be approaching people with that baseline of, we are all good people who want to do the right thing, we just need better tools to help us to do that. And I think that as we see more minorities and women in medicine and in other professions, I think that we will be getting to a better place. But in the meantime, approaching people with understanding is much better than approaching them with judgment and shaming.

Robert Pearl: Let me ask you a really tough question. As an ed physician, you see a large number of patients who are critically ill and need admission to the ICU. In many cases, they have a reasonable chance of recovery and returning to a satisfactory life. But increasingly we're seeing patients who will never speak, eat, walk, or manage the bowels and bladder, and yet modern healthcare has made it possible to keep them alive. I worry that rather than treating people, we may be torturing them as we inflict pain and produce delirium during prolonged and futile hospital stays. How do you believe we can most ethically address this problem?

Leana Wen: Wow, you are full of very difficult questions today, Robbie. So, wow. I don't know that I have a good answer to this at all. Only that this is one of many complex issues that we face in medicine. I talked about this big gray area before. There is no satisfactory answer here. And the best answer I think is one that takes into account the values of that patient. I am a big fan of advanced directives, of people discussing with their loved ones well in advance of anything catastrophic happening, about what is a quality of life that they would want, understanding that none of us can really predict that in advance. I mean, you don't know when you're going to get severely ill, you also don't know when you get severely ill about what the consequences are going to be. It is going to be

known what the consequence is likely to be. And I think that having those conversations in advance with your loved ones is really important because otherwise you are leaving your family in a very, very difficult position.

Leana Wen: And I'll give you a personal example of this. My mother was diagnosed with metastatic breast cancer which was in her 40s. And I was a medical student, second year medical student, which was first diagnosed and she passed away. And when I was a resident and I was her caregiver during that time when I was a medical training, myself, and so and have a lot to say about caregiving separately. But as it pertains to this, my mother was very clear towards the end of her life about what she wanted in terms of her wishes. At the end, she was enrolled in hospice. She did not want to have life sustaining treatments that again for her, because she had metastatic cancer and had gone through so many different rounds of treatment, she was very specific about what she did not want. She did not want to be on a ventilator for months on end with no meaningful pathway to recovery.

Leana Wen: And I will tell you, it was still very difficult. Again, this was a while ago and things have changed, but she was, even though she had explicit wishes otherwise, she was intubated and put on a ventilator. And it was very challenging for my family to make the request that she did not want this. We had all kinds of documents from her, legal documents from her. I was her healthcare proxy. Still it was very difficult for us to have our wishes be respected. And I was a doctor, right, and so I think it's so challenging for families to have their loved one's wishes respected even with all the various factors in place that the clearer you can be with your loved ones now, when again, things have not reached this catastrophic phase, the better it will be and the more we can come close to respecting people's individual wishes, which is what the healthcare system ultimately should do.

Robert Pearl: I'm so sorry for you. I had the same situation with my dad and it's part of why I got so interested in the culture of medicine, because we somehow can't accept that death is part of life and allowing it to have the maximum dignity is a major job, I believe at least, that we have as physicians. Let me ask you, you wear so many hats. You provide medical care in the ER, you teach at George Washington, the health commissioner in Baltimore, you write for the Washington Post. You're often on CNN offering insights into COVID. Does your perspective change as you put on each different hat, and if so, in what ways?

Leana Wen: Well, I don't know that it necessarily changes. I think all the hats that I wear and I'm also a mom of two, I have a eight month old and a three-year old. And so I have the mom hat too. I think all of them, all of these roles inform who I am and my views, and how I approach patient care, and how I approach thinking about medicine. I mean, I think right now with COVID, it's very challenging because we see what our patients are going through and not only the patients who are going through COVID, it's also the effects on other people too. We see patients, I saw this patient the other day, for example, who hasn't ventured outside the house, and hasn't seen her grandchildren, and hasn't been to a senior center since the beginning of the pandemic. And she is so lonely and so upset. And she

is relapsing into, previously she used alcohol and other substances and is relapsing into these and has serious mental health concerns as a result.

Leana Wen: I mean, we see the effects of COVID just affect so many patients in so many ways. And then I think to then see people not abiding by mask wearing and seeing mask wearing as something that's a political or partisan symbol and not abiding by social distancing guidelines, it's really challenging. And I think really speaks to the difficulties of where we are as a society and how intertwined those issues are that you can't, as much as we would want to just do the perfect thing when it comes to science and medicine, that's not reality. And it is really important for us to also can consider just the many other aspects that are involved in health that go beyond medicine and science, but go towards policy and politics too.

Robert Pearl: As you know, Leana, when I was a CEO in Kaiser Permanente, I was a major proponent of telemedicine, a full decade ago, and yet a decade later, a few other 5% of doctors who were offering it to patients prior to COVID. COVID comes along and there's a risk of spread and immediately the pre surge increases the 70%, social distancing requirements ease, and it drops back to less than half. What do you make of this massive variation in a short time in how we approach telemedicine, and what does it foretell about the likely availability once the COVID pandemic ends?

Leana Wen: Well, like you Robbie, I am also a big proponent of telemedicine having been a practitioner for four years. I still practice now with telemedicine for some patients in urgent care. I also, when I was the Health Commissioner of Baltimore had expanded telemedicine in different ways, including through our senior centers and in our schools, because we were able to get more services including specialty services and mental health services for our students in schools. So I'm a big proponent of telemedicine and it's been quite amazing that all those barriers that people had put up before about telemedicine seem to have faded away when we needed to get it done. And I think it's just as one more sign of how, when there is an urgent need for something, we find a way to get it done.

Leana Wen: I think that telemedicine is a useful adjunct. I don't think that it completely replaces in-person visits. I also think that telemedicine when used the right way can be a method for us to increase access, including for the most vulnerable. I certainly would not want for telemedicine just like other resources to only be used for or to primarily benefit those who are already the most advantaged, I hope that it's used as a way to bridge access for those who otherwise would not be able to get care. And I think that as time goes on, it is one way for us to increase access, and in particular, for us to consider how it could be used a long the continuum of care. So brick and mortar will still play a role, but can we also have more in-home services? Can we have mail-in diagnostic testing? Can we have telemedicine as a bridge to something else, in particular for specialty services that people may not otherwise have access to?

Robert Pearl: I totally agree that some of the easing of restrictions on telemedicine facilitated it. I also believe that the physician culture tends to perceive technology, not purely in the context of the patient, but also in the context of the doctor. We say as physicians that we always put the needs of patients ahead of ourselves, and yet we surprise medically bill, we don't offer the kind of convenience to people booking appointments, accessing their information electronically that they get in the rest of their life. We take drug company money. As we come out of this pandemic, I believe that healthcare will not be able to sustain that 5% to 6% year over year increase in costs that had happened before because the economics of our nation will have changed. What's your view going forward, and how do you see the culture of medicine evolving to better align with the needs of patients?

Leana Wen: Well, I do think that the culture of medicine is changing and will continue to change, and we can use the COVID-19 pandemic as the impetus for that change, because COVID has unmasked, it hasn't created, but has unmasked many underlying problems, including the underinvestment and disinvestment in public health. I hope that the culture of medicine will emphasize health and not just healthcare. COVID has also unveiled these underlying health disparities. And I hope that we'll have more attention to health disparities and social determinants of health more broadly. And I think that as there is a focus also on the collective, understanding that all of our health is tied to one another, there also needs to be, back to the first part of our conversation Robbie, back to and a focus on the individual, and we can do both. We can understand that all of our health and our rights are tied up with one another while also understanding that we need to be prioritizing the values of the individual when it comes to making the best decisions for our patients and those around them.

Robert Pearl: Thanks Leana for being on the show today and for providing your in-depth insights and perspectives on the culture of medicine for our listeners.

Jeremy Corr: Robbie, you posed three important questions to Dr. Wen about the culture of medicine and what doctors tell themselves. I'd like to pose them to you for your immediate thoughts and plan a show at the end of the season in which we go into greater depth. Here they are, one, we treat every patient the same based sorely on the medical facts. Two, we save life at any cost. Three, we put the patient ahead of ourselves. Do physicians consistently follow these cultural expectations, and if not, why do they continue to tell themselves that they do?

Robert Pearl: Jeremy, unfortunately, as physicians, we don't treat every patient the same based solely on the medical facts. As an example, research has found that early in the pandemic, when two patients came to the ER with the same symptoms, doctors were much more likely to order a COVID test for the white patient rather than the Black patient. The same is true when it comes to breast reconstruction after mastectomy, Black women are less likely to be offered a reconstructive procedure than white women with the same stage of cancer and ablative surgery. And data demonstrates that post-operatively white physicians

prescribe less pain medication for African-Americans than they do for their white patients after the same exact procedure.

Robert Pearl: So many doctors don't save a life at any cost. As we discussed with Dr. Wen, physicians do a great job when what is needed is emergent intervention such as we saw with COVID, but doctors don't do a good job preventing or managing the chronic diseases most likely leading to death of patients infected with the coronavirus. As an example, high blood pressure. The number one cause of strokes and kidney failure is controlled only 55% of the time across the nation, in contrast the best medical groups a successful 90% of the time. Similarly, when it comes to colon cancer, a malignancy that can be avoided or successfully treated in almost half of the cases through appropriate screening. Doctors do so only two thirds of the time. Once again, it's not impossible to achieve. The highest performing medical groups do so at 90%. It's just not highly valued. At a difference is a 40% higher mortality with tens of thousands of unnecessary deaths each year. And screening doesn't require a colonoscopy, but instead, a simple, totally safe five-minute stool test done once a year from the comfort of a bathroom and without the need for a bowel prep.

Robert Pearl: Finally, sometimes physicians do put the lives of patients ahead of their own, such as when they treated patients with COVID for 12 and even 24 hours straight, despite wearing inadequate protective gear. But at other times they don't. As an example, they send surprise medical bills to people who thought that treatment would be covered by their insurance plan, and then sue them when the patients can't pay. And they accept drug company money and attend dinners at fancy restaurants with the implied expectations they would prescribe more of a company's most profitable medications rather than equally effective generic alternatives. The reason doctors cling to these beliefs and tell them to others is cultural. When people face a situation, which they want to take an action, but they know subconsciously it's wrong, cultural values, beliefs, and norms allow them to move forward with only a minimal amount of guilt spilling over.

Robert Pearl: If you going to favor patients who look like you, fail to take the time to invest in prevention, or turn a blind eye when your lawyers sue your patients, it helps to see these actions as justified and expected. And cultural beliefs and norms help you to do that. It's not that physicians do this consciously, like smokers who don't notice when the air around them is polluted, physicians are unaware of the culture that constantly surrounds them. My upcoming book titled "Uncaring," explores the theme of physician culture in detail and how it can make doctors into heroes or fools, but more on that in a future episode. Now, let me turn the question around. Jeremy as a patient, how does it make you feel when you or someone in your family might be given different care based on factors beyond the medical details? And how does it make you feel to realize that although in some circumstances, physicians save a life at any cost, but other times they fail miserably? And do you expect your doctors will put your life and your son's ahead of theirs, or is this just too much to ask?

Jeremy Corr: Robbie, to be completely honest, this is kind of terrifying to think about. Being in America, many of us believe that we get the absolute best healthcare in the world. I know this is not always the case, as I've heard it from you, numerous other healthcare experts, and family and friends even seen it with my own eyes. I still think many of us look at our doctors as almost in such a respected role and the relationship is looked at as almost sacred. I think many of us view that doctor in the white coat similar to the way we would a priest or a pastor once they done that white collar. Robbie, as you know, when I was a day old, I was rushed to the University of Iowa hospital for emergency life-saving surgery. I've heard the story of my family doctor realizing something was wrong with me and calling in the order for me to be rushed to the University of Iowa hospital, almost two hours away hundreds of times.

Jeremy Corr: My family talks about that doctor like he was a hero because in their eyes, and in my eyes, he was. I would have passed away if he hadn't realized the problem when he did and made that rushed decision. I remember visiting the pediatric surgeon at the University of Iowa for checkups when I was a boy and I looked at him with absolute awe because he literally saved my life. My family is still close friends with one of the nurses that took care of me when I was in the hospital in the first many months of my life. My older sister had to have a major surgery when she was in junior high. The summer after that surgery, my family ran into that surgeon at the state fair. When I was a young boy, I asked that surgeon to ride on the double ferris wheel with me to which she agreed.

Jeremy Corr: I don't mean to ramble, but I've just always had the utmost admiration, appreciation, and almost reverence for physicians. And I think many people are in that same boat as me, which is why it hurts that much more when that trust is broken. Both of my grandfathers died preventable deaths. One was due to negligence by healthcare provider and the other was due to a hospital contracted infection. My aunt, a couple of years ago, experienced terrible end-of-life care, more rounds of chemo and false hope when hospice would have been the better option. It was clear to everyone that her care was not coordinated. My family felt that as though, until she got into hospice, she was being treated awfully.

Jeremy Corr: We naturally have the highest of expectations for physicians because of the reverence. Think of it like a wedding cake, to a couple getting married that wedding cake is so special and amazing, but to the baker, is it just another routine wedding cake? Is it the 10th cake they're making that week? Is that cake going to get the same attention to detail as say the cake of a local well-known business leader or a news anchor? I think a lot of that depends on the baker. Are they rushed? Are they stressed out? Are they burned out? Is there pressure from the bakery owner to get it out faster? Is this wedding cake cheap compared to the others? Or does the couple have a significantly lower budget? Physicians are humans too, and may face financial pressure, burnout and more. They will make mistakes and be imperfect. That being said from the patient perspective, physicians must self-aware that they are in that sacred and revered

role. They must do the best they can in every circumstance and always give the best care possible.

Jeremy Corr: When that trust and reverence for that sacred role is broken, it's devastating. I will go into any medical situation for myself or any family member with that reverence for and trust in physicians, because most of the time it is warranted and knowing that sometimes it is not warranted and that the best care possible might not be provided, and that there may even be harm done, is a truth that is just too earth-shattering to believe or comprehend as reality.

Jeremy Corr: Please subscribe to Fixing Healthcare on Apple podcasts or other podcast platforms. If you liked the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook and Twitter @FixingHCPodcast.

Robert Pearl: We hope you enjoyed this podcast and will tell your friends and colleagues about it. If you want more information on these topics, you can visit my website, RobertPearlMD.com. Together, we can make American healthcare once again, the best in the world.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr, have a great day.