Fixing Healthcare Podcast Transcript

Season 5 Recap

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 at 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 Forbes contributor, 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.

Jeremy Corr: His new book Uncaring: How the Culture of Medicine Kills Doctors & Patients was published last month. All profits go to Doctors Without Borders. If you want more information on the book and a broad range of healthcare topics, you can go to his website, robertpearlmd.com. Together, we also host the bi-weekly podcast Coronavirus: The Truth. Most seasons of Fixing Healthcare have six guests, but in the current season five, which focuses on the culture of medicine, we invited eight due to the breadth of the subject, and we only scratched the surface.

Jeremy Corr: In this is our final episode, I'd like to try something different. As I mentioned each of our guests from the season, I'd ask you to extract one challenge they talked about relative to the culture of medicine and expand on it based on the research you did and the conclusions reached in your book Uncaring: How the Culture of Medicine Kills Doctors & Patients. But before we begin, let me ask you to review for listeners what people mean when they talk about the word culture and how does it apply in a medical context?

Robert Pearl: Jeremy, culture includes the values, beliefs and norms that groups of people embrace and pass from one generation to the next. It's transmitted through the stories that are told, the language that is used and the customs that are followed. You can think of it on a national level, and contrast the values, beliefs and norms of people who live in Italy as opposed to Germany. Or you can think of it relative to fans of particular sports teams or the jerseys they wear and the way they show their support. Or you can observe it through seeing the impact of culture on doctors and the care they provide to patients. For physicians, culture is passed down beginning the first day of medical school. It's what's called a white coat ceremony that has become a memorable event for so many matriculating medical students.

Robert Pearl: In the audience, the students and their parents sit. And one by one, the students are called to walk onto the stage and a faculty member drapes a white coat over his or her shoulders with one exception, and that is when one of the parents is a physician. Now, think about how strange this rite of passage is.

Certainly the parents who are doctors are proud of their children, but what about the parents in the audience? Some of whom have to work two jobs, each working two jobs in order to allow their child the time and opportunity to get the grades needed to become a doctor? Surely they're just as proud of their children as the parents who are physicians.

Robert Pearl: What you quickly realize is that this white coat ceremony isn't about the pride of the parents. It's actually a rite of passage in which the parents cede the responsibility, the ability of the authority to pass culture from their family onto the faculty members. So why can the parents who were doctors drape the coat? Because they are already immersed in that same culture and can be trusted to make sure that the right values, beliefs and norms are passed on.

Robert Pearl: This physician culture can make doctors act in heroic ways or lead them to actions that harm patients. In the early days of COVID-19, physicians were heroes. They worked 12 and 24 hours at a time, donning garbage bags when hospitals ran out of protective gowns, and putting on salad lids when there were no protective masks. But the same pandemic also highlighted problems that have not only systemic reasons for their existence, but also cultural ones. And our guests, Jeremy, this season I think did a great job of pointing out many of these examples for our listeners. So please go down the list. I'll try to provide an example of the challenges the culture of medicine creates for each one of them.

Jeremy Corr: Our first guest this season was Dr. Zubin Damania, best known to his fans as ZDoggMD. He along with Zappos CEO Tony Hsieh started Turntable Health in Las Vegas as an alternate to the broken healthcare system they observed across the United States. What was one lesson you took away from his comments?

Robert Pearl: Zubin highlighted the intersection of systemic issues and cultural ones. His Turntable Health clinics emphasized prevention, patient education, and ease of access. The doctors, nurses, and staff who worked there were focused on the whole person. The clinical results were superb. And yet, the program was forced to close. The reason was the inability to get the rest of healthcare, particularly specialists in hospitals in the community to participate in the organization's evolved culture and the superior approach that it took to medical care. And they couldn't find employers willing to embrace a capitated model of reimbursement.

Robert Pearl: I think of this problem of culture and system as being similar to the two snakes wrapped around the staff on the Caduceus, the common symbol of the medical profession. These systemic issues and cultural ones are tightly entwined with each wrapping around the other, impossible to separate fully one from another. As Zubin showed, the system of reimbursement impacts the culture and the culture affects the model of payments. In order to improve health care for patients and reduce the burnout doctors are experiencing, we need to address both the failures of the healthcare system and the problematic aspects of physician culture.

Robert Pearl: As an example, research from New York City showed that 88% of people who died from COVID-19 had two or more chronic diseases. The most frequent one was hypertension, high blood pressure. And across the United States it's controlled 55% of the time. And yet, some multi-specialty medical groups control it over 90%. They have excellent doctors, but no better than in the communities around them, and they use the same medications. So what's different? What's different is how the physicians in the organizations value prevention, how they view collaboration and data transparency. Without question, insurers is the United States don't pay enough for the time that it takes to maximize prevention. But at the same time, the culture doesn't value prevention. It doesn't value the primary care doctors who help patients avoid occlusion of the arteries to the heart and brain as much as it does the specialists who unblock them after a heart attack. Both the systemic and the cultural issues have to evolve and change.

Jeremy Corr: Our next guest was Dr. Amanda Calhoun, a resident of the Yale School of Medicine and the keynote speaker at Yale's White Coats for Black Lives event. She talked about racism in healthcare. How did racism impact the care provided during the Coronavirus pandemic?

Robert Pearl: Jeremy, ask doctors why Black individuals died two to three times more often than White individuals from COVID 19, and they'll point to the systemic problems. Black patients work jobs that required them to leave their homes rather being able to dial in virtually over Zoom. They had to take buses and subways that were filled with people, many of whom were infected. And they lived in multi-generational households in close proximity with each other. Of course, these explanations are accurate, but they don't fully explain why early in the pandemic, when there were insufficient testing kits, ED doctors tested White patients twice as often as Black patients when both came to the ED with similar symptoms and complaints. And they didn't explain why doctors prescribed 40% less pain medication to Black patients compared to White patients after the same procedure.

Robert Pearl: The reasons aren't logical. The discrepancy is best explained by implicit bias. When you think about it, 20,000 years ago when a human form appeared in front of us, we had but a nanosecond to decide whether to embrace someone from our tribe, or risk being killed by a foe. We developed the ability to what is called thin-slice, make decisions with insufficient information. And that continues today. People have a tendency to be more empathetic and sympathetic to individuals who look like themselves, speak the same language and worship the same God. This is the phenomenon, as we said, is called implicit bias.

Robert Pearl: Jeremy, I was asked in another podcast whether implicit bias is racism. And I said that it wasn't, but I added knowing that it exists and not doing anything about it, that is racism. Research shows that two thirds of White doctors harbor implicit bias against Black patients. And in almost all cases, they are unaware it exists until they're tested. With the data in healthcare disparities being so clear,

there is no excuse for physicians not to acknowledge the racism that exists, their contributions to it, and to seek ways to minimize the damage that it produces.

Jeremy Corr: Our next guest was Dr. Eric Topol. He's a cardiologist, the Founder and Director of Scripps Research Translational Institute and author of Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again. What are your thoughts on technology in the culture of medicine?

Robert Pearl: When it comes to technology, doctors take two diversion paths. They clamor for multimillion dollar machines like operating room robots and proton beam accelerators, technologies that have never been proven to diminish deaths or even improve clinical outcomes. These Star War-like machines are valued in physician culture. The more they shine, the more prestige it generates, the more valued they become. But simultaneously there are other technologies that add major value for patients and doctors resist using them. The reasons most often are cultural.

Robert Pearl: One example, computers can provide evidence-based approaches that when followed by doctors lead to significantly better outcomes than when every doctor tries to decide what to do on his or her own. But culturally, doctors don't like to be told what to do, regardless of whether or not data shows that a consistent approach produces superior results. They rail at the idea of consistently following evidence-based guidelines and checklists. They label them cookie cutter medicine, and they detest when data on clinical outcomes is published with the names of individual doctors, rejecting the validity of the information every time they score in the lower half.

Robert Pearl: Second, there are new technologies that prove culturally problematic, such as artificial intelligence. Researchers have shown that in evaluating mammograms for cancer, AI can achieve more accurate diagnoses more frequently than radiologists. And yet, rather than embracing these applications, doctors point to the errors that are made by the computers, but they ignore the greater frequency of errors that humans make. This cultural unwillingness to accept machine error and overlook human mistakes isn't unique to medicine. The same response we identified with autonomous self-driving cars. Even if they're safer than human drivers by a factor of 10, any error is acceptable when it comes from a machine, but 40,000 traffic decks across the United States each year rarely make media headlines.

Robert Pearl: Listeners may think that a scientific discipline like medicine would be objective and would embrace new technologies once they are proven to save lives, but that's not always the case. Frequently physician culture stands in the way. As an example, when a doctor named Herman Boerhaave learned about a new device the thermometer, developed by Daniel Fahrenheit, he encouraged physicians around the world to begin to use it to quantify patients' temperatures, and as a means of objectively differentiating health from disease. Rather than embrace this remarkable device, it would be over 100 years before doctors began to use it. The reason wasn't the accuracy of the thermometers, but the unwillingness

of doctors to admit that a machine could be better than human fingers at differentiating normal from fever. In their minds, replacing the human hand with a mercury-filled metal device was bad medical practice. That resistance reflects the invisible force of physician culture at work.

Robert Pearl: Finally, doctors resist using technologies like telemedicine that offer the potential to provide patients with medical care that is more convenient and easier to access for patients. Seven years ago, I wrote an article in Health Affairs predicting that telemedicine will replace 30% of what we do in the medical office. For six years, nothing changed. Less than 5% of doctors routinely provided it. When COVID-19 began, suddenly the use of telemedicine soared as high as 60% to 70% of some physicians practices. Nothing had changed about the technology itself, although Congress did relax some of the regulations around its use and Medicare expanded who was eligible to be paid for the service, but even now physicians didn't agree to it's effectiveness. Invariably they describe it as inferior to making patients come to their offices. When research shows that for many problems, it allows patients to be diagnosed sooner and have treatment begun immediately.

Robert Pearl: Telemedicine isn't applicable to every problem, but based on the COVID-19 experience, I now think it can replace 40% of inpatient visits. But for doctors, this technology undermines the high value they place on their offices, and the limited value the culture places on the patient's at time and convenience. And in Uncaring, I talk about language as a powerful manifestation of culture and how doctors call the entry way into a physician's office, a waiting room rather than a reception or educational area. The resistance to provide telemedicine as frequently as clinically applicable today is no different than the desire to rely on the human hand to discern temperature rather than using a thermometer in the past.

Jeremy Corr: Robbie, the fourth guest on Season Five was Dr. Leana Wen. She's an emergency physician of public health professor at George Washington University, the former Health Commissioner for Baltimore, and now a commentator for CNN. She spoke about the powerful role that social determinants of health have on medical outcomes and the insufficient attention paid to them. How do they relate to physician culture?

Robert Pearl: Jeremy, Leana has been a powerful voice for the impact of social determinants on health and the need to address healthcare disparities that result from socioeconomic factors. And failing to address these contributors to poor outcomes is tied to the culture of medicine. I remember a conference I spoke to that was held in Washington, D.C., three years ago, and it was about caring for patients with chronic diseases. When I was done speaking, the next presenter talked about two surveys she had done. She asked the group of physicians for their list of the three greatest healthcare problems that patients faced. They highlighted items like failures in screening for cancer, failures in blood pressure management, and failures in prevention of cardiovascular disease. She then read the list compiled by the people who came to the community health center

that she ran. None of the items on the doctors' lists made the top 10 for patients. Their biggest health issues were the lack of housing, food, heat, jobs and so on.

Robert Pearl: Physician culture includes the belief that doctors should focus on a narrow range of topics in the exam room. As an example, most doctors see treating gunshot wounds as in-scope and preventing gun violence as outside. They limit their role to telling patients to exercise and eat healthy food, but it's not their job to find ways to work with others to address the difficulties people have. In doing so, when they earn minimum wage and live in congested neighborhoods. As in so many areas of medicine, culture and system are intricately and intimately linked. Doctors work incredibly hard and they don't have time to address these complex social issues. Insurance companies don't pay physicians enough to do so. But when these issues are not addressed, chronic disease flourishes and the work of the doctor and the demands on his or her time grow exponentially greater and harder.

Robert Pearl: I remember December of 2019 well. It would still be two months before COVID-19 was recognized as a healthcare threat to the U.S. The Federal government published a report predicting that healthcare expenditures would rise 5% to 6% each year for the next decade. That meant that our nation's $3.7 trillion annual spend on medical care would rise to $6.2 trillion. It would grow by $2.5 trillion by the year 2030. That's a huge amount of money.

Robert Pearl: I waited to hear outrage from national medical and specialty organizations, but none came. There was no physician group that said this is absurd. Imagine what could be done if $2.5 trillion were used to address the social determinants of health? And how much better it would be for patients? From a cultural perspective, doctors see the current approach to medicine as the right way to pay for and provide healthcare and assume that if it will cost this much over the next decades to provide medical care, that's a good unnecessary investment. The idea that the dollars could be better spent in alternatives to the medical offices, to drugs and hospitals is foreign to the culture of medicine, regardless of where they're doing so would improve health and extend lives many times more.

Jeremy Corr: Our next guest was Dr. Lisa Sanders. She's an Associate Professor of Internal Medicine at the Yale School of Medicine, and a New York Times columnist who writes the highly acclaimed column Diagnosis, published in the Sunday Magazine section, her story served as the inspiration for the television series House. She talked about the struggles of primary care in the context of the culture of medicine. Robbie, where does primary care fit into the hierarchy of medicine?

Robert Pearl: Jeremy, unfortunately, primary care medicine is near the bottom of the hierarchy despite data that show adding 10 primary care physicians to a community, increases longevity by two and a half times more than adding 10 specialists. The reasons for the relatively low status are multiple. First, medical

students see the lower salaries paid and choose higher paying specialties. What's not fully appreciated is that part of why salaries are low is the reduced esteem physician culture allocates to primary care.

Robert Pearl: The origin can be traced back to a combination of systemic and cultural issues. In the 20th century, prior to the broad availability of diagnostic tools like MRI and sophisticated laboratory studies, the intuition and personal experience of the doctor were supreme. The smartest medical students chose internal medicine for their careers, and the surgical and medical specialties were second tier. As the science of medicine rapidly advanced, and new operations and procedures were created and taught, the relative value of internal medicine and specialty medicine shifted.

Robert Pearl: With diagnosis becoming technologically-based and treatment evidence-based, the skills that primary care physicians excelled at and valued in the past became less important. As a result, physician culture increasingly elevated intervention over prevention, procedures over diagnosis. As part of the transition, the great esteem began to be given to doctors with deep knowledge in a single organ system like the heart or brain rather than to primary care physicians who were responsible for the totality of problems that patients can have. And the shift in status between specialists and primary care accelerated as hospital care became more sophisticated, doctors specializing in a patient medicine were hired, and fewer primary care physicians made hospital rounds.

Robert Pearl: In the 21st century, medical knowledge has advanced greatly compared to the century before. For nearly all of medical history, we didn't know the etiology of heart disease, the best ways to screen and prevent cancer, or the optimal way to treat various infectious diseases. Over the past decades, medical science has advanced rapidly. And for the overwhelming number of patients, there's now a recommended approach that when followed exactly produces the best results.

Robert Pearl: As a patient, this sounds great. But in physician culture, following someone else's direction, that's not valued as much as having to find your own way. Of course, there are always going to be patients who have such a complex combination of diseases, or impossible to diagnose symptoms, that there is no single evidence-based solution. But what have been the majority of a doctor's practice now has become a minority. And when each year the physician's job becomes more rote with fewer opportunities to do things that add the most esteem and respect, then satisfaction, lack of fulfillment and fatigue follow the classic symptoms of burnout.

Robert Pearl: Listen to the specialist in the hospital talk about primary care and the they'll rarely praise the valuable role doctors in primary care medicine play in preventing disease, avoiding complications from chronic disease, and coordinating the medical care delivered by an army of hematologists, cardiologists, neurologists and so forth. Often the disparage, the lack of knowledge in primary care physicians, failing to respect the breadth of problems that these individuals treat.

Robert Pearl: Finally, there's a new perceived threat to primary care with both a systemic and cultural aspect. In the physician culture, anything that can be done by someone other than a doctor. A doctor was seven to 10 years of medical school residency training. This is seen as less valuable than the work only physicians are entitled to perform. But the growing role of physician assistants and nurse practitioners, many of whom focus on the same types of complaints as primary care, elevating these tasks, no matter how valuable for patients, risks flattening the hierarchy of medicine even further than today. Unfortunately, as long as medicine continues to be reimbursed on a fee-for-service basis, it's likely the problems with primary care will become worse. Not better.

Jeremy Corr: Our sixth guests was Dr. Jen Gunter. She's an obstetrician gynecologist specializing in chronic pain, a New York Times columnist, and the author of The Preemie Primer: A Complete Guide for Parents of Premature Babies. Her comments focused on a variety of issues most relevant to women receiving and providing care. Do you see physician culture contributing to sexism in medicine?

Robert Pearl: Jeremy, medicine has traditionally been a male-dominated profession. Until recently the sexism was overt, but even now it continues, although less visibly. A recent survey published in The New England Journal of Medicine showed that 65% of female medical students report gender discrimination, and 20% report sexual harassment. In addition, they're very problematic, but subtle, but equally destructive forms. Women medical students are often encouraged to pursue specialties lower on the physician hierarchy. On hospital rounds, they find themselves being referred to by their first names when their male counterparts are addressed as doctors.

Robert Pearl: They find it harder to have their research published and be promoted as new faculty members. Even though more women than men are in medical school today, less than one third of surgical residents, particularly in the highest valued specialties like neurosurgeon and cardiac surgery, are women. And sexism happens for female patients as well. Research shows that their complaints are not taking as seriously as similar type of complaints for men. Their symptoms are often described to hormonal changes rather than reflecting life-threatening underlying medical problems. Sexism remains a major problem in American healthcare today, and it remains deeply embedded into the culture of medicine, a cultural leftover from centuries in the past.

Jeremy Corr: Alison Hadden was our seventh guest. She's a lifelong athlete, adventure and marketing executive who was diagnosed with advanced cancer at age 38, and is now grappling with a terminal diagnosis. She hosts the popular podcast No Time to Waste. She's brought a patient's perspective to the season. What did you find most interesting about her comments?

Robert Pearl: Her bravery was inspiring as she confronted death with a combination of facts and optimism. Her story highlighted three cultural issues. The first was the lack of coordination in medical care that she encountered. Doctors assume that if each specialist does what he or she feels best for the patients, and the pieces

will fit together and the care will be excellent. They don't perceive a need for one doctor to oversee all of the parts. In the past, that might've been the primary care physician, but rarely does that happen today. Patients end up having to try to hold everything together for their own benefit.

Robert Pearl: The second was how doctors viewed excellence as being whether the right drugs were administered and whether they were given into the proper sequence. They didn't include how comfortable the environment was where the chemotherapy was being administered. They didn't seem to value if the doctors all shared a common medical record. As a patient she described how much of a difference the setting can make and how important it is that all of the treating physicians have the same information and are updated on the current test results. Ambiance and convenience aren't highly valued in physician culture. For many patients, particularly in the evolving era of consumerism, they are.

Robert Pearl: Finally, I found that it amazed that at no point have any of her doctors talked to her about death, and asked what's most important to her in life. In receiving care, there have been others who fulfilled that role, but that's not the same as having the physicians who are making the medical decisions with her engage in those conversations.

Robert Pearl: In the book Uncaring, I talked about how doctors are surrounded by death for their first day in the anatomy lab when they take the shroud off of the cadaver, that they will dissect to learn the detailed anatomy of the human body. Death is ever present in the hospital and the emergency room. Death remains a physician culture a sign of failure, even when the doctor's done everything possible to avoid it. As we develop the ability to prolong life beyond the point that some patients desire, physician cultural needs to evolve to help doctors engage in these very difficult conversations.

Jeremy Corr: Our final guest on Season Five was Dr. Marty Makary. He practices surgical oncology at Johns Hopkins, wrote the book The Price We Pay and has published over 250 scientific articles, including many on the redesign of healthcare. He has spent most of his career trying to improve the quality of healthcare, and yet medical errors and failures in prevention abound. How does physician culture contribute to these problems?

Robert Pearl: Jeremy, Marty has spent his career working to increase patient safety and helping doctors embrace evidence-based medical approaches. And yet, two decades after the Institute for Healthcare Improvement reported that 100,000 patients died each year from avoidable medical error, the problems have only become worse. Figuring out why is as complex as unraveling those two snakes on the caduceus that we mentioned earlier in this podcast. There are system issues when it comes to patient safety, including lack of financial resources and insufficient time. There are technical issues, including clunky electronic health records designed for billing, not the provision of medical care. And there are also cultural ones.

Robert Pearl: As we said, physicians resist being told what to do. Sometimes it's valuable when it works to the benefit of patients, but at other times it harms people instead. As an example, we know that hospital acquired infections are a frequent cause of death. And the most common bacterium is Clostridium difficile or C. Diff, an organism that isn't spread through the air like the coronavirus, it's carried on the hands of people. And yet multiple research studies show that when doctors go from one patient's hospital room to the next, they don't wash their hands one third of the time. With the new alcohol-based disinfectants available at the entry way to each patient's room, there's no cost and no time required. The problem is cultural. And when a patient dies from hospital acquired infection, every physician assumes that it had to have been someone else's fault.

Robert Pearl: And contrary to what many people might think, it takes 17 years for a great idea, not just a good idea, great idea in healthcare, one that challenges the beliefs of doctors, to become standard practice. And the 1990s, Barry Marshall demonstrated that stomach and duodenal ulcers are caused by infection from the bacterium H. Pylori. But it wasn't until he was awarded the Nobel Prize for Medicine, two decades later, that the majority of physicians stop recommending a major surgical procedure to treat these ulcers and began to prescribe antibiotics instead. Jeremy, on Fixing Healthcare, you're often the voice of the patient. Over the course of Season Five, what have you learned about physician culture that is most relevant and how does it make you feel as a patient?

Jeremy Corr: Honestly, Robbie, it gives me mixed feelings. On one hand, I learned that most people go into medicine with the absolute best of intentions and genuinely want to help people. Medicine is a profession that has long been revered by most people outside of the medical field. Look at early on in the pandemic, there were posters and signs everywhere and posts all over social media about how frontline healthcare workers are heroes and they truly are.

Jeremy Corr: That being said, I think as the pandemic continued on, I think that attitude shifted for some of the population. Every American knows the American healthcare system is very broken in a lot of ways, but we almost never pointed the finger at the doctors. It was always at the pharma companies, or the insurance companies, or the massive systems, or the government in their cozy relationships with all of the massive lobbying power in healthcare. The pandemic has truly shined a light on the healthcare industry. This light has shown the public a lot of the issues that they may not have been aware of before.

Jeremy Corr: Robbie, telehealth, a technology that you and others have been advocating for for ages. And we've had the technology for for ages. Why when there was so much pushback and a lack of adoption for years was it adopted almost instantly when the pandemic team? Why were vaccines easily accessible for some, but not the poor minority communities early on? Why were the poor and minority communities hit so much harder by the pandemic? Why would we knew how

co-morbidities made COVID-19 much more dangerous was there not a major public health push for better diet and exercise?

Jeremy Corr: Sadly, the pandemic has been politicized like everything else in our country. The public health from the absolute top has not been clearly communicated and has been confusing for lay people. The politicians and media have spun and caused fear and distrust for their own gain, whether it is poor underserved communities seeing their populations devastated by COVID, or people hesitant of the vaccines, or people who lost their businesses or jobs or were not able to see loved ones, or even people frustrated with the confusing public health messaging. Sadly, in a decently sized percentage of the populations, physicians went from being the heroes of the pandemic to being looked at with increasing frustration and distrust. This distrust and frustration is heartbreaking.

Jeremy Corr: Robbie, as you know, I had a life-saving surgery as an infant and a lifelong medical condition. I have lived my life with a special admiration and appreciation for doctors. There's this trust in frustration as I said is so heartbreaking to me. Even as I heard from the experts on our show about the instances of racism, sexism, hierarchical issues, resistance to change, burnout, how not all patients are treated the same and more, I have not lost this admiration for doctors.

Jeremy Corr: I feel the issues with physician culture are terrifying. I don't want to risk having a burned out doctor giving surgery to my son, or having a doctor who will not want to talk to me about my end of life decisions where I'd receive a terminal diagnosis. I saw my aunt have needless extra rounds of chemo and given false hope when she should have been made comfortable in hospice care. To look at it like a football team, her care team clearly had no quarterback coordinating the care. What was the most frustrating part for my family was how fragmented at all felt. I lost both my grandfathers to preventable medical errors. And as I said, the issues with physician culture absolutely terrify me. And I believe rightfully so.

Jeremy Corr: That being said, I think the season has really given me hope that we have some of the right thought leaders and brightest minds out there that will help lead this change to fix the physician culture. Robbie, how has the book Uncaring: How the Culture of Medicine Kills Doctors & Patients been received overall? And how have doctors reacted to your pulling back the curtain on physician cultures for patients to see?

Robert Pearl: Jeremy, overall, the book has been enthusiastically endorsed. And so far, all the book reviews have been excellent. This week on the BookAuthority list of the best new books in healthcare to read for 2021, it was ranked number one. And Kirkus, the industry leader in book reviews, gave the organizations esteemed star rating, an honor reserved for less than 5% of new releases.

Robert Pearl: It's gratifying to me how many people have written to tell me the same thing about the book. They've said, "I've known that something wasn't right in my

interactions with the medical system for years, but I never could describe it clearly. You've done that for me." And nearly all readers have talked about the various patient stories and how many have brought tears to their eyes.

Robert Pearl: When it comes to physicians, nearly all of those who have read the book have thanked me for writing it. They're proud of the work they do. And they appreciate the chapters that are laudatory about the commitments and the dedication that they demonstrate. And they're also aware of how the culture of medicine has harmed patients and doctors. Many found the story I tell about a physician who took his life without any of his colleagues being aware that he was suffering three heart-wrenching and unfortunately, reminiscent of stories that they knew all too well.

Robert Pearl: And finally, there were a few doctors who are irate that I breached the wall of silence. Some wrote in all caps, punctuated with exclamation points. And it's wrong to say that physicians contributes in any way to today's healthcare problems. They insist that doctors are only victims. As a physician, I understand the reaction. It's very hard being a doctor today. The demands from insurers, regulators, patients and hospital administrators feel unending and impossible to fulfill. Doctors are dissatisfied and burned out. And I completely agree with them that the system of medicine is deeply flawed and it must change. It Is why I wrote my first book Mistreated: Why We Think We're Getting Good Health Care and Why We're Usually Wrong.

Robert Pearl: But I believe they are also influenced by the culture of medicine and reacting to the esteem that has been taken from doctors over the past two decades. Kübler-Ross described the five stages of grief associated with loss, and their reaction reflects two of them, denial and anger. Unfortunately, there's no way to reach the final stage of acceptance without going through them. It's why I anticipated this type of response and welcome it because I believe that it will lead to more dialogue, more discussion, and it will move healthcare evolution forward more rapidly.

Robert Pearl: Acceptance includes the need to acknowledge the realities of today and be willing to make the changes needed in that context. Rather than seeing themselves solely as victims, doctors will need to act to reduce racism and sexism, embrace modern technology, make care more convenient for patients, elevate the status of primary care, accept the inevitability of death, and maximize clinical outcomes in patient safety. They'll need to do more than point out the moral injury that's been done to them. They'll need to join together to improve the medical care they provide. And when they do so, I'm confident that they will not only diminish the harm done to patients, but the harm done to doctors as well. And when both happen, I'm optimistic that we will once again make American medicine the best in the world. I offer my gratitude to our eight guests this season for pointing out both the wonderful aspects of physician culture. And it's more problematic underbelly. I hope that we'll be able to evolve the latter while never, ever relinquishing the former. I thanks to them and thanks to you for hosting Season Five.

Jeremy Corr: We hope you enjoyed this podcast and will tell your friends and colleagues about it. If you want more information on physician culture, you can find it at robertpearlmd.com. Congratulations, Robbie on the success of your book. I know it will stimulate discussion and debate and improve healthcare for all Americans. Please subscribe to Fixing Healthcare on Apple podcasts or other podcast software. If you like the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook or Twitter @FixingHCPodcast. Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.