Fixing Healthcare Podcast Transcript

Interview with James Madara

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 Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong. His new book, Uncaring: How the Culture of Medicine Kills Doctors and Patients was published two months ago. 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 host the biweekly podcast Coronavirus: The Truth

Our guest today is Dr. James Madara, the CEO of the American Medical Association and chairman of Health2047, the wholly-owned innovation subsidiary of the AMA. Earlier in his career, Dr. Madara served for 20 years as a tenured professor of pathology and director of the NIH-sponsored Digestive Disease Center at the Harvard School of Medicine, then chair of pathology at Emory University and most recently the dean of the University of Chicago, Pritzker School of Medicine.

Robert Pearl: This is our sixth season of Fixing Healthcare. In our first season, we brought in nationally recognized leaders like Don Berwick, Eric Topol, Ian Morrison, and Zubin Damania, aka ZDoggMD, and asked them to describe how best to fix the American healthcare system. Their solutions were comprehensive, spanning across the realms of insurance, hospitals, the drug industry and physician practices.

Robert Pearl: This season, rather than asking for comprehensive solutions, we're going vertical and deep, inviting leaders from each of these areas to come and explain the work their organizations are doing to address the healthcare challenges our nation faces, the problems they're encountering, and their perspectives on the future.

Robert Pearl: And I can't think of a better first guest than Dr. James Madara, the CEO of the American Medical Association. Welcome, Jim.

James Madara: Well, thank you for having me, Robbie, and great to join your conversation.

Robert Pearl: And congratulations on completing 10 years in this role, and for all you've achieved. Let me invite you to offer your views on the contributions the AMA has made, the work you're currently doing, and why the nation's largest

physicians' association will be a major contributor to solving the healthcare problems of tomorrow.

James Madara: Well, thanks. I would start at both ends of our 174-year span. We began as an organization that was focused on clinical ethics and education, and getting educational standards established for medicine, and there were none at that time. We were encouraged by the states to step into that space.

James Madara: As to the last 10 years, the more recent end of our spectrum, we have a rolling five-year strategic framework that has three components. Dealing with the tsunami of chronic disease, hypertension and pre-diabetes in particular. Chronic disease entails about 90% of our nearly $4 trillion healthcare spend and we're getting more and more chronic disease, not less and less. And now COVID is adding to chronic disease as well.

James Madara: And then, the second major strategic arc is lifelong education, training physicians for the 21st rather than the 20th century. Started with medical schools, a consortium of 37 medical schools, now reimagining residency and an educational hub as well that's digital and online.

James Madara: And then third is removing the many obstacles that interfere with patient-physician interactions, so that we can get better outcomes and a healthier nation. And what we've learned across these three arcs is that three accelerators really speed the work in each of these arcs. And they are advocacy, which is a way of memorializing progress and legislation and regulation. Innovation, very important in all of these arcs. And a different type, including our own innovation company in Silicon Valley, Health2047. And then, the third accelerator is health equity. If we really aspire to having uniform quality, safety, et cetera, we can't do that with the great inequity we have currently.

James Madara: So that's our strategic framework. It's been having good progress, I have to say. And the other thing I would have to say around it, Robbie, is it really requires us to interact with others, to partner with other organizations to get these things done. And those three arcs represent what I would call pre-competitive challenges. And what I mean by that is that if you can't make progress in these three areas, it doesn't matter what health system we have mid-century, it won't work very well. For any health system, regardless of the type, to work, we have to deal with chronic disease, we have to have physicians educated for the 21st century, and we have to have better interactions and more fluid interactions so patients and physicians can spend time together.

Robert Pearl: You raise many key areas, I'd like to double back to all of them. But let me start with something you mentioned, which is COVID-19. It brought out the heroic side of physicians and physician culture, with doctors providing care 12 and 24 hours at a time, often without the protective gear they need. Do you think they were adequately recognized for the heroic work they did? And how are we going to continue to support doctors going forward?

James Madara: Well, I think physicians were well-recognized, they just weren't well-protected. And so, it created a moral dilemma for many physicians in that they were used to running to problems and running to trouble if the trouble was disease, of course. But they always imagined that the system would have their back in terms of protective material and whatnot. That got straightened out, as you know, as the pandemic went on and it went from a need for stuff, stuff, stuff to a need for staff, staff, staff later in the pandemic.

James Madara: I think, looking back on it... I hope I'm saying that correctly, I hope we're on the other side. I would say that it was kind of an extraordinary function of our healthcare system that showed a lot of resilience. And there were times when it looked like it would break in certain cities. It really never did, although people paid huge personal prices for that resilience. And when we think of the monoclonals, the new vaccine platforms, mRNA platforms that were astounding in terms of the time and turnaround of those vaccines. When we think of physicians learning from each other how to stay away from ventilators, simple things like pronation that were really helpful. It was really marvelous to see.

James Madara: But, on the other hand, it did point out long-term systemic problems of our healthcare system. And some of those were related to our strategic arcs that I pointed out. The abundance of chronic disease. In fact, those with hypertension, diabetes, obesity, were among those at highest risk for death. The challenging aspect of a physician working in the 21st century that is a team-based activity. We did learn, also, that if there was some more laxity given in paperwork and regulatory burdens, physicians and physician teams of health professionals could function better. We learned that we still suffer from lack of data liquidity and meaningful interoperability of clinical data. And then also punched out, of course, was the fact that our health disparities really put Black and brown communities at substantial risk relative to others.

Jeremy Corr: At the beginning of the pandemic, the average American viewed healthcare providers and public health experts as heroes. Like everything else in America right now, the pandemic has become highly politicized. You still have people who view physicians and healthcare experts as heroes, and others who have been frustrated with confusing and inconsistent messaging from the government and public health experts, as well as things like those dancing TikTok nurse videos that were going around. What are your thoughts on how the messaging of the pandemic has been to the general public? And how do you think that that could have been and could be improved for the future to really show what heroes doctors and nurses actually are?

James Madara: I think there are two things, two things that immediately come to mind, Jeremy, that could be thought about. And the first is that the messaging around health and science should come from trusted sources and not be politicized. So it doesn't matter if someone's on the left, if it's a politician on the left, a politician on the right, a politician in the center, if that person becomes the mouthpiece for healthcare during a pandemic, it's immediately politicized. So, leave the messaging to trusted folks that are in the field and can give a balanced message.

Specifically, it would have been good to hear more of Dr. Fauci and perhaps less of those in administration and political positions.

James Madara: The second thing I would mention is we have to... I think we're never going to have the population entirely understand, or want to understand, the scientific method. People are busy. When they get home, they don't want a lecture on scientific method, they want to have dinner and play with their kids. And so, how do we, given the vagarities of scientific method, how do we think about that? Well, one way of thinking about that is to always be sure to use the right phraseology, and that is not, "We think..." That is not, "X should be done at this stage of the pandemic." The phraseology should be, "Based on our current best understanding, X should be done," allowing room for understanding and new evidence to mature. So, I think some of the messaging was off-base in both of those ways.

Robert Pearl: Jim, a major advance during COVID-19 was telemedicine. What are your observations about what we've learned, the challenges that still exist, and the future of virtual medical care?

James Madara: Well, that is a really amazing story. I would say that in three months in 2020, telemedicine advanced in a way that I would think that it would've taken 10 years to advance. A lot of things were around that. Some were patients didn't want to go into hospitals and clinics. Secondly, physicians needed to have follow-up with some of those patients and see them in a different way. But also critical were the regulatory domains were relaxed, and physicians... This was, within a period of two months, it wasn't a 3x increase in telemedicine or a 10x increase, it was a 100x or more increase in telemedicine.

James Madara: And I think not everything can be done by telemedicine, it's hard to palpate the abdomen by telemedicine. But a lot can be done, and it could be upwards of 30, 40% of what needs to be done, particularly in follow-ups. Hopefully, the regulatory relaxation will be kept, and also the appropriate reimbursement so one can have a sustainable practice will also be kept. Those things are being thought through now.

James Madara: It also puts a finger on the really radical change of where healthcare is done. In my own career, we went from 60% hospital, 40% outpatient at institutions where I worked to the reverse, 40% inpatient, 60% outpatient. And now we see it moving to home. And so, we'll have this continual shift and the technology is going to be really important to make this work well. And one of the glitches that needs to be resolved is, again, the interoperability that occurs in electronic record. In other words, you'll need point-of-care data from the home. You'll need ways of attesting that that's signal and not noise. You'll need ways of bluetooth reporting that to the cloud and then downloading it into an EHR in a way that it can self-organize. And that's going to be very important in the development of that field.

Robert Pearl: We've discussed on the show before this challenge and talked about the need for the electronic health record companies to open their APIs. Do you see this happening any time in the near future?

James Madara: Well, there's certainly some sticks being introduced by ONC towards this end, but frankly, I don't really see it happening very much. It still takes effort by a patient to get a record transferred, and the whole EHR systems, as you know Robbie, were built from practice management systems. And so, they're better for administration claims and billing than they are for organization of clinical data needed at the point-of-care. And that's a problem that needs to be fixed. The major vendors in our country are still server-based and not cloud-based. That increases the cost and complexity of the system and institutions. So, it seems to us to be an area in need of great overhaul.

Robert Pearl: Jim, I saw an article today that said that 70% of physicians now work for either a hospital or a healthcare organization, and that 50% of them are employed by these entities. I wonder how this has impacted the AMA and what do you see in the future?

James Madara: Yeah, so that's exactly right. Now, some of the employed are employed by physicians in larger physician groups. But I think the number that you gave, 50/50, reflects some of our own data and experience, including among those employed, if they're employed by, say, an institution versus a physicians' practice. So, 50/50 sounds about right.

James Madara: What it means is that we are now engaging individual physicians, as we always have, paying attention to them, but also groups of physicians. This is something that's happened in the last two years. In fact, one of your old stomping grounds, I believe, Kaiser Permanente, is one of our groups that joined the AMA as a group membership. And there, we take a slightly different approach.

James Madara: So, for example, those leading groups or institutions that employ a lot of physicians may not need some of the aspects that we have. Insurance project products, JAMA. They already have our journals, but what we can do is show them a tool where we can measure burnout rates in their institution. We've then developed another tool, in collaboration with Harvard Business School, that will allow them to estimate the dollar cost loss sunk in having this degree of burnout.

James Madara: And then we have mitigation tools to lower those degrees of burnout and we can predict, if you lower it by one point, two points, five points, the economic impact that will be had. And as you know, there are a lot of other impacts, too. Burned out physicians retire earlier, they work fewer hours, there are risks in terms of quality and adverse events. So, it's something that we really need to pay attention to and mitigate, not only in the group practices, but in small practices as well.

Robert Pearl: Jim, you mentioned equity, and I know the AMA has recently embraced and introduced quite a number of initiatives around eliminating racism. Can you tell listeners a little bit about the past and a lot about the future?

James Madara: Yeah, so a little bit about the past, I would say this. That people think that there's an overt racism if you say something like structural racism, but if you look back at our own past, there's something familiar to you, the Flexner report of the early 20th century that had a consequence of making more academically rigorous programs in medical schools, and also had a consequence of having many medical schools close. Well, among the medical schools that closed were the majority of, at that time, African-American medical schools but most universities at the time were not accepting African-American students. So, an untoward consequence that was unanticipated was freezing African-Americans out of the field of medicine. And to this day, we have fewer particularly black men that are serving as physicians in the United States.

James Madara: And so, this is part of our past. We, at one point, thought that having more intellectual rigor in medical school was a good thing, but then we look at the consequences of this, where there were some schools that had no place to land and then students that couldn't be placed only because of their race. So, that's the past that we have to live with, and I think every organization has a piece of that similar story because that's the history of our nation.

James Madara: So now, going forward, we have to recognize those things that happened in the past. We have to think about how we can correct them. We have to own our own pasts, and then we have to look to the future of how we can repair, and what is our role in helping repair the inequities that occur in healthcare in this nation.

Robert Pearl: What are a couple of examples that you're focused on right now?

James Madara: So, a couple would be a creation of a health equity fellowship in collaboration with the Satcher Institute at Morehouse Medical School. And these are some early and some mid-career physicians that are interested in having a career devoted to this field of health equity and improving health equity. So we build up a cadre of experts in this field. The first group was just accepted. I believe there are between 10 and 12, but there were over 200 applications. So that is one way of thinking about it.

James Madara: Another way of thinking about it is joining a group here in Chicago called the West Side United. The West Side is an underserved population in Chicago, and we have invested, as has Rush, Northern Trust, and a few others, invested in a way where the dollars will be used to impact the community as the community organizations see fit. And we will be there to help. And we see that as a model program that, if successful, could be expanded to other cities.

James Madara: A third example I'll give is from our Health2047 innovation shop on the West Coast, and that's the launch of a Medicare Advantage company called Zing. Zing has the same economics as other Medicare Advantage companies, of course, but it crafts its benefits, its accoutrements, to underserved populations as opposed to most MA programs that mimic the programs that folks had when they were employed in large corporations. So these are just a handful of ways, and we have more, that we're attacking this problem.

Robert Pearl: You mentioned at the beginning the AMA has a longstanding code of ethics that dates back about 100 years, maybe even longer than that. But society is always evolving. How does the AMA think about whatever the code of ethics is at the time, whether it's outdated, how it needs to evolve? Issues around social media, gun violence, consumerism, political divisiveness, the list goes on and on. How do you see this code of ethics as a living, evolving organization, and how do you know when it's not moving fast enough?

James Madara: That's a great question. The first document produced by the AMA after its founding in 1847, that same year, was the first code of clinical medical ethics. I think that was the first code of clinical medical ethics in the world. It's a one-pager, and a copy of it is hanging on the wall in my office. The current code of medical ethics runs over 300 pages and just went through a major update year before last because of all of the issues around transplant, treatment, harassment, these kinds of things. So, it is a living document. It is very complex and many institutions have adopted it for their own code as well.

Robert Pearl: As CEO, you're often put into a position of having to take a position around a piece of legislation or a political push. I can think back to, originally the AMA was against Medicare, now it's a very strong supporter of the program. How do you approach these problems? And again, how do you recognize when a decision of the past is not the best one for today or the future?

James Madara: So, let me back off a little bit here and just say a word about our governance. People think of us as a membership organization, as we are. About 270,000 physicians, we've had membership growth each of the last 10 years now after about a 40-year decline in membership growth. But another piece of the organization feels more like an organization of organizations. And that's our house of delegates. It's composed of 180 medical societies, so the society of every state, every specialty, the four branches of military medicine, the territories, et cetera. They make up the house. And the house is the instrument that defines the policy of the AMA.

James Madara: Now, although the numbers of direct members may be 27%, something like that, as represented in the house of delegates by these 180 societies, it's almost all physicians. It's hard to identify a physician that doesn't belong to his or her state society or some specialty society. And so, that's a voice of physicians, broadly. There are about 600 delegates in the house. They debate in the same way Congress does, and those policies represent the policies of the AMA.

James Madara: Now, there are over 3,000 of those policies, so they tend to be more narrow than a piece of legislation typically is. So, when a piece of legislation comes to us, and we work with the regulators in trying to sculpt it as well, we're not looking for 100% alignment with policy. We're looking for 70/30, 80/20, and that we view as an overall win. But there's not going to be a large piece of complex legislation that comes out of Congress that aligns with every single policy that we have with no conflicts. So, that's the way we put it together.

Robert Pearl: So, let me take an example to me, which is the debate today between, I'll call it pay for volume and pay for value, or capitation versus fee-for-service. The two different variants of reimbursement. How does the AMA think about this issue, approach it, push it in one direction or another? Where do you see the future moving?

James Madara: We think of that more in terms of principles. So, the principles are is access increased or decreased? Is the safety net enhanced or diminished? Our physicians treat it in a way that there is some consistency over time, so they're not treating it in a way where there's a fiat, and by fiat, their lives change every six months or so. And then we look at legislation as to legislation that aligns with those principles.

James Madara: Now we, as an organization, think that we're probably going to have a pluralistic healthcare system. I know there's been a lot of talk about Medicare for all, but as you know, it's not as though Medicare has no problems. It has a cap on it, there are several other issues around Medicare. What we'd rather do is look at a pluralistic system that abides by these principles, and those principles mean things like access, consistency, removing administrative burden, strengthening the child health programs, protecting the safety net.

Robert Pearl: I guess maybe I'm showing my bias now that I think that the capitated approach does that better by having physicians benefit when patients stay healthy and avoid disease and align with the chronic disease approach that's there. Is that a direction you can see the AMA pushing towards moving American medicine? Or do you see it more as the AMA having to respond to wherever American medicine moves?

James Madara: Yeah, so I think the answer is it depends. So, if it's a two-sided risk capitation, a capitation with two-sided risk, well then the question is, is the risk allocation appropriate? And then the other question is, of course, if you're a physician and you have 1,200 patients in your panel, one outlier can bring down the practice. So sure, as long as it's done in a reasonable way.

James Madara: Now, I have to say, a lot of people looked at capitation a little differently, particularly in the front end of the pandemic when patients disappeared. And these were people not doing critical care at their institutions, and so they were left without a busy practice. Capitation kept them afloat. In fact, for the first time, I heard that described as prepaid medicine during that period.

James Madara: So again, we think we'll be in a system where there's a pluralistic response. Some of it will be capitation, some of it will be other forms of health system responses. I do sometimes wonder... Stuart Altman at Brandeis, in a talk, was talking about the Massachusetts experience. And he said the experience there was characterized by going after one complex variable at a time. And the first complex variable they went after was access. And then, after fixing access, trying to get to the issue of cost. And it's true that healthcare is awfully complex and there are a lot of variables. And I sometimes wonder if, by trying to create systems where you change five variables at once, how much you're really going to learn.

Robert Pearl: Interesting, because you're absolutely right. That's also been our nation's approach. The ACA took on expanding insurance coverage before it undertook reducing the cost of medical care.

James Madara: Yeah, and the other thing that's related to this that has been slightly frustrating for us is the Center for Medicare & Medicaid Services Innovation Center wanted physician-led programs that would save costs, that would reduce costs and increase value. And the physician technical advisory committee was set up to help with this. There have been no fewer than 16 programs developed, anywhere from inflammatory bowel disease to emergency department utilization with cost savings and increase in quality and outcomes that just have not been engaged and embraced by CMS, and we're disappointed in that.

Robert Pearl: I know you're very focused on this issue, but primary care is obviously lagging in terms of fulfillment, satisfaction, numbers, go down the list. It's particularly adult primary care is a major challenge for the United States today. How does the AMA view this? And what do you see as the AMA's role in trying to address both the shortage and the great problems and difficulties that primary care physicians are experiencing today?

James Madara: Well, we have several efforts in helping physicians in primary care practices. There's work going on right now. I would say, Robbie, our work is always typified by first doing the science and collecting the evidence. Right now, we're looking at a series of practices that seem to be efficient, where physicians are pleased to be in their practices and trying to nail down, definitionally, what makes that so.

James Madara: The other thing I would say, even more broadly, that goes beyond primary care but almost all physicians, relates to a series of studies we've done in collaboration with others. The first was with RAND Health several years ago, maybe it was eight years ago, seven, eight years ago, where we looked in multiple markets and we looked at what satisfied physicians and what dissatisfied physicians. So, some were institutional, some were small practices, all the different modalities and fields. But the answer seemed pretty uniform. The largest satisfier was face time with patients. And that face time with patients gave physicians a sense that, when they were driving home at night, that they had done a good job for their patients that day, they had enough time

to spend with patients. And the dissatisfiers were everything that deducted from that. So, the administrative complexity, the use of the electronic medical record for data entry, et cetera.

James Madara: And then, a subsequent study was done, multi-market again, in collaboration with Dartmouth, and it's a study that's been well-reported. Most people know what the study showed, but it basically showed that... It was a time/motion study and it showed that for every hour a physician spent face-to-face with a patient, which the RAND shows is the intrinsic motivator, they spent two hours doing administrative burden, and much of that was data entry. And that's not counting another two hours, on average, of what was called pajama time at home.

James Madara: And then, a third study that we're doing with Mayo and Stanford, we started with Mayo about 10 years ago and we do every couple of years, is the study of burnout, which is very high and had been increasing. So you can that these folks are in a cognitively complex field. Their intrinsic motivation is spent time with patients. Their reality is time with the computer and paperwork, and they end up burned out.

James Madara: And so, we have a lot of time that we could harvest from the physician workforce we have if we just made the environment around them function better.

Robert Pearl: One of the opportunities I have besides hosting this podcast is to be on other people's podcasts, and I thought of that when you were talking about the AMA's commitment around medical education. One of the things that people often ask me is how do I think medical schools should evolve, and I point out the fact that if you wanted to carry all of the medical knowledge with you in the 20th century, even 1990s, you had to have a 50-pound backpack. And today we call it a smartphone, and I don't believe that medical schools have recognized that memorizing arcane facts is no longer the key skill that doctors have to have, and it's the actual application of that information. What are your thoughts about it? I know the AMA has taken a major role in trying to evolve it. Where do you see it going?

James Madara: I think you're exactly right, Robbie. The way I would put it is in the future, how you learn may be more important than what you know. Of course, you have to have a base of knowledge, but having that base, you can never take a base of knowledge that is broad enough given today's literature and numbers of diagnoses, the expansion of the literature that we have. So, that's going to be very important.

James Madara: One of the ways that we're thinking about that with our own ed-hub is to create a digital platform where education is much more easily accessed. So, we've created this where all the AMA content, anything from JAMA to ethics to health systems science, and then we thought if we could create a program, a digital

backbone that was attractive enough, that others would want to use that too, we could co-brand. And that's been the case.

James Madara: We started this about a year and a half ago, two years ago, and now we have several major societies, the first being the American College of Radiology, and others. We have organizations that provide genetic information and content, like Jackson Laboratories. Stanford, as a school, is on the backbone. We now have three state licensing organizations on the backbone, and we have multiple boards like the American Board of Internal Medicine on the backbone.

James Madara: And so, one can get digital content more readily. As soon as you get that digital content, the CME is registered and goes to your board. And then, ultimately, as we get more boards and states, can also be used for state licensing. So, that drag is no longer there.

James Madara: A promising tool that we'll be trying in the field this year comes from a collaboration with Health2047, our shop on the west coast, and it's a AI-driven tool that can go into a physician's panel, the electronic record representing that panel, interrogate that panel in terms of what is actually seen in that practice, and then create bespoke curricula, so that we don't have physicians doing this box-checking anymore where, based on their general field, they're required to know things that have nothing to do with their practice. So, I think those kinds of approaches will be needed in the future as well.

Jeremy Corr: Dr. Madara, a lot of people see just how much lobbying power the healthcare industry has, including from organizations such as yours, and worry that this lobbying power helps shape legislation that is in the best interests of profit for the healthcare industry and not in the best interest of the patient. What are your thoughts on that, and how would you explain that to a Washington outsider, or just a patient who's kind of curious about the healthcare lobbying industry in general and AMA's specific efforts in lobbying?

James Madara: Yeah, thank you. At a meta level, we lobby for one thing, and that's our mission statement. And the mission statement is to promote the art and science of medicine in the betterment of public health. And then, under that mission statement, are the policies of the house that make what we lobby for more granular. And those relate to the principles that I outlined. Those principles would include greater access, stronger safety net, stronger children’s health program, consistency in the healthcare system, removal of administrative complexity so people can spend time with patients, and patients seem to want that extra time with their physicians as well.

James Madara: So, those are things that we lobby for. Now, does some of that touch on compensation? Well yes, because any field and any employed individual does not want their compensation to volley around, up and down, by fiats. Everyone wants some consistency. If they stay in their job for 10 years, 20 years, 30 years, they would like to have some consistency during that time and not have high volatility. And so, it's really largely about the larger mission statement, the over-

arching mission statement. To the degree that it touches on things like compensation, it's really about having something that's stable and practical, which every employee in the United States aspires to.

Robert Pearl: Two last quick questions. The first is, in our last season of Fixing Healthcare we talked about physician culture, values, beliefs, the norms that we learn in medical school and residency and carry with us throughout our professional careers. What do you see as being the best parts that we need to keep? And what do you see that needs to evolve?

James Madara: Well, I think the intrinsic motivation for entering the field, we need to keep, and the altruism around that. But frankly, we beat that out of our students a lot during their time in medical school, and they can lose that professionalism. And they can become somewhat damaged and cynical. And that is something that I think is really important to fix now.

James Madara: And frankly, that cynicism that is its own curriculum in medical school by those that are on faculty and in house staff and whatnot, some of that, I think, is also driven by the elements that I mentioned. People going into a field with the aspiration of seeing people face-to-face and helping, and then seeing the administrivia aspect of it.

James Madara: One of our newer programs, which is Reimagining Residency... So, we have 37 medical schools. The question is, well now how do you make a smooth handoff of these students going through an innovative program to the residency? So we created a program, Reimagining Residency, just launched. There are 11 healthcare systems that are funded through this mechanism, projects. One of the projects is a joint project by Hopkins, Stanford, and University of Alabama, Birmingham. And the first part of that is, "Well, now we know how physicians spend their time. How do you residents spend their time?" And a resident, time/motion studies, residents on different services will, on average, spend far less than 50% of their time when they're in the institution either in education or directly seeing patients with patient care. It's a system that's set up to build a kind of cynicism for that that enter with this other, altruistic thought and mind.

Robert Pearl: And it's not surprising that we see burnout in medical school, and burnout in residency, and burnout continue into clinical practice. Last question. I want to applaud the AMA for the positions you've taken around anti-smoking legislation, efforts to control the opioid epidemic, and a focus on obesity. Now we have gun violence, climate change, immigration, social determinants of health. Are we asking doctors to take on too many of society's problems?

James Madara: Yeah, I think there is... Physicians are going to weigh in, but the question will be what is our role in the larger ecosystem? There's some things we'll be primarily responsible for. There will be other things where we're part of that team. But much of what you've laid out, we have policy around but the policy, sometimes, was defensive in nature. So, for example, pediatricians in Florida were being told that they could not, if they thought they should, they could not ask their

patients if there were firearms in the house that were available to them. These are things that directly affect the ability to practice medicine, so we have pieces like that, that are directly related to the practice of medicine, things that happen in the physician's office. And then we have the downstream events, where it's the folks in the emergency departments and our trauma units that have to deal with the consequences of gun violence as well.

Jeremy Corr: What do you think it's going to take for Americans to regain their faith in the American healthcare system and public health experts? Not just in terms of the pandemic messaging, but in the face of rising healthcare costs, and just seeing how far behind the industry is when it comes to things like price transparency and more consumer-friendly technology.

James Madara: Yeah. Well, I think like anything else... Well, first of all, I'll take physicians as an example. The yearly assays of trusted populations among the population still has physicians near the top, or at the top in terms of trust. But I think the way you improve your reputation is through facts and action more than PR. So, you create systems that allow interactions from your home with physicians that are productive and meaningful. You have physician-led teams that work well. You do decrease the administrative burden so physicians can spend more time with their patients, which we know patients want as well.

James Madara: In terms of the public health system, the public health system, I think, was affected in the following way. During the SARS epidemic, more funding went to it. After the SARS epidemic, folks looked around for money and they chipped away at the public health infrastructure. And then, lo and behold, during the pandemic the public health infrastructure was not well-established. I should say there are probably data transfer problems within the public health system from city to county to state to federal, and that mirrors the problems in data flow through the healthcare system as well. So, both systems have that problem of data flow and data liquidity and data organization.

James Madara: And then, lastly, I think we have to define in a clear way a better structural interaction between public health and healthcare, beginning by defining who's responsible for what.

Robert Pearl: Jim, any final words you'd like to leave the listeners with?

James Madara: I would just say that healthcare has been under a lot of pressure. Physicians are burned out, problems we have to deal with that, particularly after the pandemic. But all in all, it's just a wonderful, wonderful profession to be in. It's wonderful to be part of a population that helps caring for people. And so, I hope folks that listen to this will consider that as a career option.

Robert Pearl: And like you, Jim, becoming a physician was the best professional decision I ever made. I want to thank you for being on the show today. Your comments were incredibly insightful and your vision for the future is one that should inspire all

of us, whether we're physicians or patients, but all of us want the best for the American healthcare system. Thank you again, Jim, for being here today.

James Madara: Thank you, Robbie. Thanks, Jeremy.

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 recent book. I know it will stimulate discussion and debate and improve healthcare for all Americans.

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