Fixing Healthcare Podcast Transcript

Interview with Don Berwick

Robert Pearl: Welcome, Don, to season seven of Fixing Healthcare.

Don Berwick: Pleasure to be with you, Robbie.

Robert Pearl: This season is dedicated to breaking the rules, and I can't think of anyone in American healthcare who's done more to break the rules on behalf of patients than yourself. And the rules I'm talking about aren't the ones found in textbooks or learned in academic lecture halls, and they're not the legal or regulatory ones. They're the ones you and I learned in medical school and residency training. We learned by observing our senior residents and the attending physicians. Most of these rules were never spoken and none are written down, but all are communicated effectively.

Robert Pearl: We know that it's a rule because we can observe merely all doctors across the country doing them. But when the data says there are better ways, the rule persists and change rarely happens. So, let's begin with your commitment to patient safety. Doctors take an oath to, first, do no harm, and we tell each other we never inflict harm, but you broke that unwritten rule, the rule never to admit how much harm we do. How did you become aware of a nation's failures and how did you set out to address them?

Don Berwick: I think actually most clinicians, physicians, nurses, pharmacists are well aware of the amount of injury that occurs to patients because of errors in their care. It's part of a normal experience. I can easily recall patients in which there were mistakes. And I think that it came home to me, especially when I had the unfortunate experience of my wife's serious illness in the mid-1990s, when I could observe firsthand accompanying her error after error after error, problem after problem every day. But I was already aware of it. I think the other side of that problem is the way we're trained as clinicians to deal with hazard, which is through heroism.

Don Berwick: I was taught, romantically, that it's my patient and if something goes well, it's my success. If something goes badly, it's my problem. And so, we personalized mishaps and that's not scientifically correct. Most injuries to patients like most hazards in any situation are systemic. They're built into the way that the things flow. And this myth that somehow it all depends on the individual is a hard myth to break because I was trained in modern approaches to improvement systems thinking and ways to think about interdependency.

Don Berwick: I became able to see the problem of patient safety as a systemic issue, which can only be fixed through systemic changes. Those are very hard to achieve, but it's the only route.

Robert Pearl: Don, you left the Harvard Community Health Plan earlier in your career and co-founded IHI. Why did you do that? And what were your goals?

Don Berwick: Well, IHI, the Institute for Healthcare Improvement, was the brainchild of a group of people, friends of mine, and I who had begun meeting regularly one way or another, formally responsible for improving healthcare in our local organizations. We were all spread all over the country. We had independently discovered the work of some of the giants outside healthcare who had thought about how to improve products and services, W. Edwards Deming, Juran, a group of Japanese scholars.

Don Berwick: And we became convinced that there was a lot known about how to improve complex environments, complex systems that was not being used in healthcare. Basically, we decided to try to improve that. It began with a demonstration project that my colleague, my new colleague, Blan Godfrey, who was the head of Quality for Bell Laboratories. And I cooked up to see if we introduced experts from outside healthcare to healthcare organizations, could they help, could they begin to identify some of the problems and help fix them? That demonstration project lasted about year and a half. It was extremely successful.

Don Berwick: The answer was yes, scientific improvement could work in healthcare with appropriate adaptation. And then, this group of friends and I began to see the need for some a nonprofit home for advancing will ideas and execution around continuous improvement. That became IHI. Nonprofit started in 1991, still exists, very vibrant, national, international now. It's all over the globe. In fact, I just gave a speech virtually in Australia to the IHI British Medical Journal forum on quality improvement and patient safety in healthcare.

Don Berwick: And there were hundreds and hundreds of people from all over the world attending that forum in Sydney. So, it took off, and there's a lot of interest. It is still an uphill battle, Robbie. As you know better than anybody, it's making these changes to actually make healthcare what it needs to be is very, very hard.

Robert Pearl: This is why I'm so interested in this rule-breaking notion. And we talked about looking outside of medicine and bringing in experts who are not doctors, not even clinicians, not even trained in science necessarily, or at least the science of biology. You did it. What allowed you to do it when it seems so difficult to happen inside the medical profession?

Don Berwick: Friendship and colleagueship explains any success that I've had with that. I've never done anything alone. It's with a group of people like you, Robbie, who understand that we've got to make changes, our oath as you said needs to be honored, and that's only going to be done if we change the way we deliver care. I think that the lesson I learned early on is that the receptivity in the workforce is enormous, once offered the opportunity to improve the work they do to get really involved in all the dimensions of excellence. The vast majority of people in

healthcare, doctors, patients, nurses, pharmacists, they really want to make changes. And if you can drill down to that energy, you can have success.

Don Berwick: One of the most dramatic positive experiences in my career, I think was the 100,000 Lives campaign back in 2004. The architect was my colleague still, Joe McCannon, but we developed the idea of trying to mobilize energy throughout the nation in hospitals to adopt a relatively simple set of changes that would save lives by improving processes by standardizing and spreading practices that worked. Well within, oh, barely six months, we had over 3,000 American hospitals enrolled in that project.

Don Berwick: And the energy level was, it was really thrilling. It was moving. I think Robbie, there's a will in the workforce to work on making things better systemically that can be unleashed through proper leadership. And that I think if there's any secret of success in IHI, that's been it. And a lot of it is volunteerism. This is not about big industrial efforts. It's about letting people help. And the volunteer energy is not just in the US but around the world for improvement are enormous. That's what IHI I think has been able to tap into. Not alone. There are many others that have done that, but it's extraordinary.

Don Berwick: I think also, adhering to the science. I don't want to give too much gloss to this, but there are scientific foundations for making things better. Understanding systems and working at a systemic level, instead of, as I said, individual heroism, using data properly. We misuse data all the time in healthcare. We don't use it to help illuminate variation and how things are going. We use it to make judgments or to provide incentives and rewards, which I think is bankrupt. Information can really help unleash knowledge. And that's part of the plan. Part of it is learning to cooperate.

Don Berwick: We are so fragmented, so broken apart in healthcare, but you can improve patient journeys without high levels of respect and cooperation across many, many boundaries. And that's been very difficult to achieve partly due to our financing system. And then, we refer to in our field, PDSA, Plan-Do-Study-Act. It's a mnemonic to help remember that you improve by trying things, you improve by getting... you learn to ride a bicycle by getting on the bicycle and healthy organizations are always, always trying new things, reflect on what they've learned from it.

Don Berwick: Everyone's involved. This is what I call the science of improvement. And it involves leadership who understand it and then allow it to thrive. That's probably the biggest problem is leadership focused on improvement.

Robert Pearl: I still believe that most clinicians, even though they see the medical errors, they believe that they're doing the best that's humanly possible. And I think that contributes to this reticence to engage in the types of quality improvements, even though their hearts are in the right place. I think the actions change, but

I'm interested in understanding how did you come up with such an audacious goal, a 100,000 Lives?

Robert Pearl: You could have said 10,000 lives or you could have said something else that would seem more easy to accomplish. How did you have the audacity to set your target so high?

Don Berwick: The evidence we had on the rate of injuries to patients was pretty secure, Robbie. I had been a member of the National Academy of Medicine, Institute of Medicine Committee that wrote 'Crossing the Quality Chasm' and the report before that, 'To Err is Human.' Thanks to pretty systematic research around the country research led by Dr. Howard Hiatt, his colleagues in the Harvard Medical Practice study, excellent work going on in Europe and Australia. We had plenty of evidence about the rates of injury and they're extremely high.

Don Berwick: No one knows exactly how many patients die each year from mistakes in their care. But it's in the hundreds of thousands probably in the United States. And by the time of our campaign, the 100,000 Lives campaign, we had the National Academy of Medicine report, which summarized a vast literature. And that number was supportable.

Robert Pearl: Well, true. But how did you think you could get more than 10% improvement from the 90% or 100%?

Don Berwick: Back of the envelope calculations. First to your earlier comment about clinicians, yeah, I think clinicians do feel they're doing their best because they are doing their best. They're really, they're normal human beings, flawed, frail people, in difficult context, trying as hard as they can. The quality improvement science says trying harder is the wrong plan. It can't work. You're already trying as hard as you can. The problem is you're in a context which doesn't allow you to be reliable. People are getting ventilator pneumonias because we don't have a total system for management of ventilation.

Don Berwick: According to modern science, we people get central line infections because we haven't organized the system to support reliable application of preventive steps that effectively prevent central line infections. And by 2004, when we launched this campaign, we had the evidence. We could see from work that IHI had done not just in the US, but around the world, that hospital by hospital, clinic by clinic, we could see the results. We had hospitals by then that had zero ventilator pneumonias for two years running.

Don Berwick: We had hospitals that were approaching zero for central line infections. We knew from Australia that rapid response teams were changing the profile out of ICU cardiac arrest. So, we had the data. And when we extrapolated that data to our massive healthcare system in the US, that 100,000 Lives, it came into view, it came into reach. Was it for sure? No. Was it exact? No. Even to this day, we

don't have an exact number of the number of lives that probably were saved by that pain, but we had the data, Robbie. We still have the data.

Don Berwick: And so, the trick is to learn to think systemically, for clinicians to understand that they are citizens in complex environments, much bigger than themselves. And only when we get involved in, buoyantly, happily, joyfully get involved in celebrating and working in those interdependencies with the support of leaders can we make progress. It's really frustrating to try to be a hero all the time. It doesn't work.

Robert Pearl: As part of the campaign, Don, you gave one of, if not the most moving speeches I've ever heard. You said, and I quote, "The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And though there are known, we will know that mothers and fathers are at graduations and weddings they would have missed, and their grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that without our work, would never have been."

Robert Pearl: The rule that we follow as doctors is that all that matters is the patient in front of us. And you broke that from my perspective, by focusing on the people left behind. What gave you that insight? What led you to do that?

Don Berwick: Prevention is always hard for the reason that I mentioned in that paragraph. You don't actually know what doesn't happen, but once you bring a scientific lens to this problem of excellence and get honest about the data, you can see it, you can see the harm. And so, for me, it wasn't that hard step, Robbie. I could see the harm. And I guess back to personal experience, reflecting on my personal experience as a patient or a loved one of a patient, I could see it. I could see the injuries in my own experience. So, we all. I've given many speeches about safety and it stuns me. I think, Robbie, this has been your experience also.

Don Berwick: When you're in an audience, when you're speaking to an audience of 1,000 or 2,000 people, and you say, 'Who here has personal experience of a complication or error in healthcare that could have been avoided in yourself or a loved one?' Every hand goes up, every hand goes up. And so, I'm just one of the crowd here, people that have experienced this and say, 'No, enough is enough. We need to stop this.

Robert Pearl: I still think it was brilliant to have focused on all these other impact, people and the impact that it has upon them. Because as you say, we don't value necessarily the preventive services for some of the reasons we say, but the idea of how wide the impact of safety can be, at least I found that moving and motivating, and every time I hear your speech, tears literally well up in my eyes. So, I just think it was a brilliant idea. And again, as a rule breaker, you can see

past the expectations that we have, the limitations we placed to how it's going to really resonate with people.

Robert Pearl: And I think that was a major part of the success you had, taking it outside of the individual, to the grandparents, to the children, to the other people who would be left behind, not just the harm to this one patient, but the impact it has on a family and loved ones in an entire community.

Don Berwick: You've been one of the real voices in the country, Robbie, reminding us about that personal side to the care. And it's there. A quick story, during the 100,000 Lives campaign, my young staff at IHI on their own initiative, rented a bus and shrink-wrapped it with logos from the campaign, and then drove the bus across the country, holding rallies in cities. I think there were 15 or so stops with the healthcare community, the city coming together to celebrate and commit to 100,000 Lives campaign.

Don Berwick: When that bus got to Badger Stadium in Wisconsin, I think it was, they drove into this stadium and the staff, hundreds of staff from the local hospitals were there. And what they had done was outline 1,200 seats in the stadium with the yellow balloons. And this was their symbol of the number of lives they could save in their geographic area if they committed fully to 100,000 Lives campaign.

Don Berwick: They brought it home together as a community with a visible image, and talk about tears. Every time I see that slide, I choke up a little. That will was there at the start and what the campaign did was mobilize it. And that's the secret of improvement. That's what happens when you do this right.

Robert Pearl: Just so beautiful. You mentioned prevention. I want to ask you about that rule that we have, that interventions is more important than prevention. If it weren't for that rule, we would control hypertension 90% of the time, screen for colon cancer 90% of the time, pay primary care doctors far more than we do today. How do we go about as an American society breaking that rule?

Don Berwick: I don't know, Robbie. We're in a hammerlock right now. The incumbent financial system is so deeply invested in the technologies and processes of acute care. Some of which are miraculous, lives are saved every day by organ transplants and heart surgery and advanced chemotherapy that we should never give up, never ever give up. But in order to support that technocracy, we've developed a financial architecture that is confiscatory. It takes everybody's money and talk about breaking rules. The rules for payment, the rules for profit, for greed that allow greed to enter the system are costing us dearly. And I think the incumbent system doesn't want to change it. It doesn't want to see that money shift.

Don Berwick: We know where to put it, Early Childhood Development, strong education systems, workplaces that thrive. Supports to lonely, to elders to avoid loneliness, community infrastructures, like food security and transportation security and housing security, anti-racism, reform criminal justice. We know

where that money should go if we really want to be a healthy nation, but we starve the infrastructures that could produce health in order to support the massive architecture of intervention.

Don Berwick: Some of that must be retained. We need to do every surgery that works, but the greed, the pricing games, the market concentration, the acquisitiveness of the system, it's eating us alive. And we won't have the energy or resources devoted to prevention until we break that hammerlock. And I don't know how to do it. It's political. And unfortunately, I think we physicians and nurses who care about health are going to have to be politically active to break the stranglehold that this incumbency has on money right now. It's very, very destructive.

Robert Pearl: It would be a great conversation, because I believe the first step is to change how doctors and hospitals get reimbursed. And if we got reimbursed in some form of prepayment, I like the notion of capitation. We then would have the incentives to drive that because that's where the profit would be rather than today, where it's simply related to the volume of things that we do and the intensity and that rewarding of the system, I think has a perverse impact upon our decisions and starting in medical school and continuing throughout our training the rest of our lives, but that's a different conversation for a different day.

Robert Pearl: So, let me return back to this theme of breaking the rules. Don, I first met you on a trip to Sweden. We went there to, you organized the trip, so that we could hear from the staff in a particular hospital and the work they were doing, the outcomes they were achieving. The unwritten rule of American medicine is that we're the best in the world. We have little to learn from other nations. What was so special about that facility and its people? And what do you believe American doctors can learn from their success?

Don Berwick: I remember that trip well, Robbie. First, your basic point, we really need to become globalists in our thinking. It's not un-American to ask how other nations and other communities deal with health and wellbeing and at what price, it's instructive. And we need to have a humility to do that searching. You're remembering a trip to Jönköping County in Sweden. At that time, Sweden paid for its healthcare through general taxation and healthcare was provided at the county level.

Don Berwick: There were, I think 21 counties, and one of them, Jönköping County, a hundred miles or so west of Stockholm, is the highest performing of the 21 counties in Sweden, which is one of the highest performing countries in the world. They're delivering care with measured outcomes superior to those in the United States at about half the cost. I've been there many times. I have many friends there. It's extremely high performing. It is by the way, as devoted to prevention and community health as it is to superb acute care.

Don Berwick: The hospital we met in, Robbie, was Region hospital, which is a tertiary, quaternary hospital that could... it's equal in performance or better than any of the best in the US. We were trying to understand on that trip, why is this difference there? Why are they spending half the money and getting much, much better results? And it was hard to unlayer it. Some of it had to do with salary structures and pricing.

Don Berwick: Some of it had to do with a sense of, I guess, what I'd call appropriate frugality, not spending resources that don't help people, focusing all of the money on what really helps. There's also part of the culture there in that county and maybe in the country, a solidarity, a communitarianism that allows them to raise questions across boundaries and optimize the system, not subsystems, to optimize for the patient, not for the particle.

Don Berwick: You may recall the Esther project in which the whole county, 370,000 people or so I think it was, the whole county health system was focused repeatedly on the metaphor of Esther, elderly woman who had congestive heart failure and depression and a bunch of other burdens. Esther did not exist but she existed in their mind. And their constant conversation was how will we all help Esther? That ability to work together, I think is one of the secrets behind the superb performance of lower cost there. But they're not alone.

Don Berwick: I've been in many, many places around the world that are much higher functioning than American healthcare overall, but they do it with a sense of solidarity that we lacked. Your earlier comment, Robbie, for our next conversation about global budgeting and capitation, I could not agree with you more. You taught me that. Watching what Kaiser Permanente has done, it's a different place that thinks differently.

Don Berwick: It's got its own problems. We know that, and it can be better, but it's able to think about duty to a population and sorting resources where the resources are needed. And that's what you saw on that Swedish visit.

Robert Pearl: As part of your answer, you made me remember a quote you, or a response you gave when you were being appointed to the head of CMS. And you talked about that there's 20% to 30% of healthcare that is, in quotes, "waste." Usually no benefits to patients and that some of the needless spending is a result of onerous, archaic regulations enforced by the agency. And I'd like to ask you about a couple of parts of that sentence.

Robert Pearl: The first is the unwritten rule that I see in medicine that we believe as doctors, that everything we order and do is necessary. And yet as you point out, as much as 20% to 30% of it may not be. How do we help doctors to be able to see that 20% to 30%, or at least, let's just say more than see but actually act upon that to eliminate that, to generate the resources that we could use in different ways?

Don Berwick: That's another breaking the rules issue. Basically, there are two steps. One is we have to see the waste, and then we had to decide to get it out of there. And back in 2012, I wrote an article in JAMA. Yes, estimating 34% waste at the median in the expenditures in this country using a model that I developed with colleagues at RAND Corporation. I actually, Robbie, thinks it's higher. I think we're closer to 50%, but I'd be happy to agree on 30 or 25. A recent repetition of my own research by Will Shrank colleagues came up with a number around 25%. It's big. We're talking about hundreds and hundreds of billion dollars, billions of dollars a year.

Don Berwick: Some of it is what you say, some of it is the expenditure of money on care that cannot help. I'm not talking about futile care. I'm talking about redundant care or unscientific use of procedures and tests for example, or visits. There's another version of this though when you talk about breaking the rules. I did write a paper in JAMA called Breaking the Rules for Better Care a number of years ago, based on our work at IHI with a collaborative with a network. We have a network called the Leadership Alliance.

Don Berwick: And I will unashamedly issue an invitation and an advertisement here in anyone listening to us your organization ought to join the Leadership Alliance. Right now, it's about 50, 55 places. We did a study, informal study about four or five years ago in which we invited those organizations and 24 agreed to break the rules. And what we did was we asked them to survey physicians, their own staff, medical and non-medical, patients and visitors, staff, patients, and visitors for stupid rules. That is, write in a rule that makes no sense when you think about patient care that at least it made sense one time, but it doesn't make sense now.

Don Berwick: Twenty-tour organizations in one week harvested 360 nominees for stupid rules. Every one of those rules cost money, cost time, demoralized staff or patients, put up barriers and had no sound logic anymore. We divided them into four categories. Some were regulations like a CMS regulation or Joint Commission, but the other three categories were myths, things that people believed about rules that were not true like HIPAA myths. People constantly talk about HIPAA, but HIPAA doesn't speak to what they're talking about.

Don Berwick: Administrative prerogatives, that is things that administrators could change without any outside reference. And habits, habits, myths, and administrative prerogatives. Of the 360 stupid rules, 85% were not regulations. They were not CMS. They were not the Joint Commission. They were just stuff we do that we could stop by realizing what the truth is, by amending myths, by simplifying administrative procedures.

Don Berwick: There are billions and billions of dollars and millions and millions of hours that could be restored to real value for patients and vitality for staffs. So, if we could just do that, wake up. It was buoyant. My goodness, the organizations involved loved it. I hope they followed through and support that rule-breaking. We

repeated it by the way in Europe, same result. Our alliance in Europe had an equal number of rules there. So, it's not just an American phenomenon.

Robert Pearl: Let's look at the second half of the sentence. I doubt that the other leaders of CMS have ever described the agency rules as onerous and archaic. Why did you say that? And were you concerned about political consequences as a rulebreaker, admitting that the agency that you're now going to run is out of touch with reality?

Don Berwick: Well, first, we had a presidential order to look at wasteful regulation. President Obama issued an order for all agencies and cabinet secretariats to look for rules that made no sense. He was right on top of it, right out of the Oval Office. And so, we had plenty of support politically. I remember going to the staff and saying, "Let's, for starters, I want you to bring me 50 regulations that we should stop, 50 regulations that don't help." And there was a little grumbling. And then, they went away. And it's about a week later, the senior staff brought me a list of a hundred and they weren't done.

Don Berwick: We then issued a reg to take away those regulations. It was possible to do to clean house. This is lean thinking, this is the Toyota production system at work. So, all systems have that level of, I'll call them stupid rules or waste. They all have their defenders. They all have their history, but people can see it. And once you have leadership that says, let's stop it, you can make progress.

Don Berwick: Now, that's not easy for all rules. One of the rules that was nominated by the survey we did with our Leadership Alliance that got the top vote around real regulations was the three-day rule for having to be in a hospital for three days before you could go into a rehabilitation setting, that's pretty dumb. And that would require a serious investment by CMS and possibly even statute to change. And that's a hard one, but most of the time, it's our habits.

Don Berwick: And when you go to the workforce and you say, "I know you see waste, and I want to help you get it out of the system. I want to help you stop it." Because it's eroding your spirit, not just the pocketbook. The staff will do it. They will join you. And I've seen that over and over again. And so, it didn't really take much courage.

Don Berwick: It was ripe and ready. And luckily, we had the president behind it. I do believe that CMS and the Labor Department were the two lead agencies for that rule changing.

Robert Pearl: Yeah. A rule that we tell ourselves inside medicine is that we provide great medical care to all. And again, you've broken this rule by acknowledging that the current system actually is rationed, a word that few people want to use, but when you step back and look at it, it makes very accurate sense. Why did you break this rule about the discrepancies in the medical care we provided? And what response did you get when you broke it?

Don Berwick: Well, it's infuriating to see how much of inequality and racism still manifest in the way the healthcare system is constructed and operates. Being poor is really bad for your health in this country. And that's because we don't have the safety nets that we need for people who are at a disadvantage. Being a person of color in this country is hard on your health. And it's because we haven't addressed the generators of that inequity. We're starting to. The Biden Administration has been relentless in its continuous focus on equity as a theme for its work. And I commend him for it, but we really have a long way to go.

Don Berwick: I personally don't believe we have to ration care, not if we're wasting 25% or 50% of the money. We got plenty of money to give everybody all the care that could help them. What we do right now is we ration people to care. We say, 'Because you live in this place or because your color of skin is dark, or because you have little money, you can't get what others get.' And it's offensive. It's wrong, it's morally incorrect and it's technically incorrect. And by the way, it's bad for the economy.

Don Berwick: And the basic commitment we need to get that solved in America is to solidarity, equity and mutuality for all. We're all in this. One of the arenas that's caught my attention since I was in administration, for example, is the criminal justice system. The travesty, it's a travesty. We incarcerate more people in this country per capita than any other developed country on earth. By far, they are seven to one ratio of Black, five to one ratio of Latino.

Don Berwick: And it is, as Michelle Alexander's brilliant book talks about, it's The New Jim Crow. It is extremely expensive. And from the viewpoint of the oath we took as clinicians, dead wrong because 70% of the people in our prisons and jails have mental illness or problems with substance use. And if we had a healing preventive approach, a restorative approach, reentry approach so that we would have much less incarceration, much healthier people and lower cost.

Jeremy Corr: Don, earlier you discussed inequity in healthcare and how the Biden Administration is focusing on helping improve care among minority communities. Having grown up in rural Iowa, I know one group that often feels forgotten about is the poor rural White communities. These communities often has less and less jobs, lower incomes, issues with meth and alcohol, schools that are falling apart, are far away from any grocery stores, doctors' offices and hospitals.

Jeremy Corr: What is being done currently to address the health inequities in these communities? And if you were put in charge of improving the healthcare of these poor rural communities, what would you do?

Don Berwick: Well, disadvantage is not racial only. Rurality and the exclusion you're talking about also afflicts the health and well-being of people. We need to find where deprivation exists, where people don't have what they need, be that food or transportation or broadband and make an investment, envision a country of

equity, including the equity you're talking about, Jeremy. One of the most costly misunderstandings lies out there is that somehow the interests of the disadvantaged White people in this country are in conflict with the interests of the disadvantaged people of color. They are not, they're the same interest.

Don Berwick: And I abhor, I reject, I cannot accept the demagogues who thrive on creating division. So, were I in charge, which I'm not, I would say we have got to have a sense of stewardship of responsibility for people who are at disadvantage. There's a quote from, I think it's Saint-Exupéry, the author of the Little Prince that I wonder if I can remember it.

Don Berwick: It's, to become a man... I think that's gendered, but to become an adult is what he meant, is to accept responsibility for redressing harms that you did not cause. And I deeply believe that. So, the community you just talked about, Jeremy, absolutely needs to be centered in our sites.

Robert Pearl: I'm talking about breaking rules, you're a physician, maybe the nation's leading health policy expert. And then, you decide to run for governor of Massachusetts. What made you run? What was your platform? Would it have worked?

Don Berwick: In the experience of working in the administration, President Obama's administration was instructive and inspiring for me. It was very hard. The contention in Washington, the lack of civility, the inability to have rational conversation across boundaries, that's frustrating. The lying was frustrating, but the general ability to work with government constructively using the skills I have in improvement was the highlight of my career. With CMS, I was able to bring in training for the agency on quality improvement. I was able to bring patients and families and clinicians into the building and start to listen to them differently.

Don Berwick: We were able to have launched a replica of the 100,000 Lives campaign, a partnership for patients that was aiming for patient safety improvements that that was very successful. So, despite all the political obstacles and misbehavior, I could see what government really can do for people, especially the people that's there to protect, the children and elders and people with disabilities. So, I was very inspired by that. And when I left Washington, I left it reluctantly. The Republicans refused to confirm me after President Obama's recess nomination of me.

Don Berwick: So, constitutionally, I was the administrator, fully empowered, but I had to leave after 18 months or so because that's when the clock ran out on my recess appointment. But I thought it was amazing. So, when I came back to Massachusetts, what I began to feel was the country needs confidence. It needs buoyancy. We need to see success instead of wringing our hands about all these failures. To do that, we have to be together and we have to use government. Government is not the only answer, but it's part of the answer.

Don Berwick: My training and my background as an executive, the governorship was open and I decided to go for it to see if I could possibly get into a position to create an example for the country of improvement as a theme in government across all sectors. I also believed thoroughly in the multi-sectoral view of health. And I knew that as governor, I could begin to insist on cooperation among agencies, all of which affect health and wellbeing. That's what I saw in Sweden where everyone's health is a shared responsibility.

Don Berwick: It was an amazing experience. It did validate for me the good soul of the Commonwealth, the voices of communities that people care for each other, they care about each other. I didn't win. I wish I had. Could I have been successful? I don't know.

Don Berwick: It wouldn't have been easy, but I think, yes, I think that a leader that can pull disparate elements together and say, 'We're a team, we've got to do this together. Your people depend on us.' The voice of the people into the room that use systematic improvement methods in science has a good shot at success. So, no, I'm not sure, but I would've loved the chance.

Robert Pearl: The final question, Don. One thing I've learned about rule breakers this season is that for every rule they've broken, there are five more that they're ready to tackle. What's next for you?

Don Berwick: Well, the boundary that I'm running at now is the boundary between health and healthcare, our earlier conversation about what I would call the confiscation of resources by the technical system, which is a good system. It's trying hard. I know that, but it's adopted a level of entitlement to resources without attention to waste and the rules that should be broken that you're talking about, Robbie. And it's not okay. It's not okay. It means our schools are starved. The elders are lonely, our kids are not getting a fair shot in stressed environments. It means our infrastructures upon which healthy communities depend are all threatened.

Don Berwick: And healthcare's a generator of that. It's cause of that. And so, my latest windmill that I'm trying to tilt that is, can we please rebalance? We need to get resources to the aspects of our communities that actually produce health, even while we do all the surgery that matters, but we've got to be more disciplined about making sure that every dollar we spend in healthcare helps health and every dollar we waste is recovered and reallocated to the vulnerable parts of society that are currently stared by an overgrown healthcare system.

Don Berwick: I don't think that's a battle that's easy to win. As I said earlier, the incumbencies are very strong, but we need to have that fight. And so, yeah, I guess I'm remaining a technician, but remaining also political. I also think, Robbie, that's global issue, not just the domestic one that I can't see that the responsibility to help disadvantaged population stops at our borders. There are billions who need help, and I think we need to help them.

Don Berwick: Part of that is climate change. That's my wife's area. And so, another aspect of rebalancing is to try to do something to own up to what we're doing to this planet, because it will come back. It will come back to haunt us. So, that's the field of engagement I'm in right now. And won't stop.

Robert Pearl: My view is that clinicians are at the heart scientists and scientists need to be driven by evidence. And that if we could acknowledge the evidence that exists about the futility and relative impotence of so many of the things that we do, that would be a good place, that rather than starting with, how do you take money out of a system or starting with the fact that somehow people are not acting appropriately, that we begin with saying, "What does the science say and how can we follow the science?"

Robert Pearl: And I believe like yourself, that there's enough waste generated by actions that we take that rather than improving lives actually compromise them. And that if we could just stop doing the things that both harm patients directly, the patient safety work you've done, but also harm them by overtreatment in ways that inflict pain and suffering, and don't prolong a positive life for them or their relationships with their loved ones that we all of a sudden have the dollars that we could then invest.

Robert Pearl: And I look forward to the conversation about how should we better invest these dollars to maximally improve people's health, whether it be in better nutrition, whether it is in better communities, whether it is in better exercise opportunities? Wherever it might be. I want to have that conversation about how to reuse that money in order to improve the health of our nation.

Robert Pearl: As you know, Sidney Garfield who founded the Permanente Medical Group would say, "We don't need a sick system. We need a healthy system." And I think you and I both concur around that.

Don Berwick: We do, Robbie. There's a leadership seat that's empty right now to make the case you just made. And in our dreams, imagine that the clinician community, I think it's doctors and nurses come together with a voice, not of self-interest, but of investment in the wellbeing of the community. If we ever could find the platform and the voice to do that and the generosity, and really give up some of the habits we've had of just seeking more and more and more for ourselves, the seats available.

Don Berwick: And I think the public would breathe a sigh of relief to have a clinical community that talked about what you just said about getting resources to where the need really is. So, I won't stop dreaming.