Fixing Healthcare Podcast Transcript

Interview with Devi Shetty

Jeremy Corr: Hello and welcome to our Fixing Healthcare podcast show, Breaking the Rules. I am one of your hosts, Jeremy Corr. I'm also 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 Medical 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 books Mistreated: Why We Think We're Getting Good Healthcare and Why We're Usually Wrong, and Uncaring: How the Culture of Medicine Kills Doctors and Patients. All Profits will go to Doctors Without Borders. If you want information on a broad range of healthcare topics, you can visit his website at robertpearlmd.com.

Our guest today is Dr. Devi Shetty. He's a heart surgeon trained in both London and the United States. He currently owns and operates 11 hospitals in India. The ability of his teams to perform heart surgery on patients a few days old, to very senior in age, at a cost that is less than a 30th of the least expensive American hospitals, with the results that match the best in the US, has led him to be featured in leading medical journals and the Harvard Business Review. I know listeners will be inspired by the work that he does on behalf of the less fortunate every day.

Robert Pearl: Good morning, Devi. Welcome. I know you're in India, we're in the United States, and it's great to have modern technology connecting us together, despite the problems of COVID.

Devi Shetty: Thanks. Thanks, Robbie.

Robert Pearl: This season is dedicated to breaking the rules and I can't think of anyone in healthcare who has done more to break the rules, to break the norms, to make the changes in expectation on behalf of patients, than yourself. The rules we're talking about aren't the ones found in textbooks or learned in academic lecture halls, and certainly they're not legal or regulatory requirements. They're the ones we learned in medical school, in residency training, we observed our senior residents and the attending physicians and however they behaved, the ways they thought ,were ones that we copied. Most were never spoken and none of them were ever written, but they all were communicated effectively. And we know they are a rule because when we look across the country or around the world, we see all the doctors doing the same thing, even when the data says there are better ways. But I thought it'd be fun today to start with a question that actually is about you but not a result of you. You were Mother Teresa's physician. Why would she choose a cardiac surgeon as her personal doctor?

Devi Shetty: Yeah, Robbie, I was privileged to be living in Kolkata at that time, and Mother happened to have a cardiac ailment, and I was a senior doctor in the city, so it's

just a coincidence or God's blessings that I had the privilege of being close to Mother when she needed the doctor's help, and I'm grateful to God for the opportunity.

Robert Pearl: That's terrific. And I'm sure, and I know actually, that she really appreciated your wisdom and most important of all, your caring. So let's go to the rules of medicine. In the United States, at least, the expectation is that heart surgery will cost 50,000, 75,000, 100,000, dollars and you break that rule, you do heart surgery for 1,800 dollars a case. Why and how?

Devi Shetty: First of all, Robbie, I like the title of your program, of breaking the rules. I would ask a question, do we have a choice? We really don't have a choice. We can continue to charge the patients what we have been charging before, in the process, a tiny percentage of the country's population can undergo the heart operation. If a solution is not affordable, it is not a solution. You may know, Robbie, that across the world, among all the largest industries, the largest industry is the food industry, it's a 12 trillion dollar industry, next to that is the healthcare industry, which is a 10 trillion dollar industry. Every other industry looks like a tiny industry compared to healthcare industry. But sadly, after spending $10 trillion, less than 20% of the world's population has access to safe, accessible, secondary and tertiary level healthcare. Now, if all the people of this world decide that that is unacceptable, at least half the world's population have the choice to get the best healthcare, then we need $20 trillion, which doesn't exist in this world.

So we have to break the rule and we have to do everything possible to make healthcare accessible, affordable, and safer for the patient. So we are able to do it only by the economy of scale because we are blessed to be living in a country with 1.3 billion people. So we have a large number of people coming to our hospital and getting the procedure done, and in the process, our outcome gets better, our cost goes down. About 14% of the heart surgery done in India is done by us, so we have an unfair advantage to reduce our cost.

Robert Pearl: For our listeners, not only do you do the surgery at $1,800 a case, but your results are as good as the best in the United States. And we can get in some details soon about how you accomplish that. But let me ask you about a different rule, which is when I get asked, "Well, Robbie, you're a doctor, what do you do?" I tell people, I fix children with cleft lip and cleft palate. Other people will say they take care of the nervous system or they take care of the gastrointestinal system. I've heard you answer that question by saying that you set the price for a human life. What do you mean by that and why do you say it?

Devi Shetty: Robbie, we live in developing countries. A typical doctor like me, I see about 50, 100, 130 patients every day in my clinic, apart from one or two surgeries. And good number of my patients are the little children sitting on their mother's lap. I examine the kid, I look at the mother and tell her that, "Look, your child has a hole in the heart. She requires open heart surgery." She has only one question, and the question is not about the scar, about the recovery or how to take care

of the kid later on in life, nothing. Only one question, how much it is going to cost. And if I tell her that it is going to cost, say 100,000 rupees, which she doesn't have, that is a price tag on the child's life. If she has 100,000 rupees, she can save the child. If she doesn't have 100,000 rupees, she's going to lose the child.

This is what I do from morning till evening, putting price tag on human life. This is what every doctor in all the developing countries do from morning till evening, putting price tag on human life. This is not acceptable, Robbie. If society has given legally, officially the right to put a price tag on human life to people like us, we have failed as a society. This can't go on.

Robert Pearl: Again for listeners, you do a large amount of free surgery, it's just that you can't do everyone for free or you can't pay your staff and buy the equipment that you need. So this price tag is the measure by which you need to be able to run the hospital, and I know that you're working hard to lower it even further, which to the American surgeons listening in, will seem impossible, but I'm actually optimistic that you're going to succeed. Let me ask you, early in your career you came up with a plan to do surgery for the poorest farmers in India and you priced their care for the cost of a pack of cigarettes a month. How did you come up with this idea breaking the rule for how care is provided, by in essence creating not just insurance but insurance for the poorest people in your nation?

Devi Shetty: That happened about 17, 18 years ago. There was a drought in the state of Karnataka, where I live. So farmers lost their capacity to pay for the healthcare. At that time, we approached our government that we have very strong network of cooperative societies. Millions of people are members of cooperative societies and they sell milk, they sell cashew nut, they sell the sugar cane, and they're very powerful and they have a very good relationship with the government. And we told the government that if the cooperative society members, they pay 11 cents per month, that's approximately the price of one packet of cigarette or Beedi, what they smoke every day. One day he doesn't smoke and that money he pays for his health insurance. And initially we had about four, four and a half million people paying 11 cents per month, and fortunately, Karnataka state government agreed to become a reinsurer. If you go broke without insurance, government would step in. But fortunately most of the time, we managed to break even by ourselves.

The insurance pays only for the surgeries, starting from a routine surgeries like gallbladder, hernia, cesarean section to heart operation, brain operation, everything is covered. And we networked with about 400 to 600 hospitals across the state, and these members could go to any of the hospitals. There are about 650 varieties of surgeries done on the human body and we recognize all those surgeries. And at the end of, I think, 12 or 13 years, over one and a half million farmers had varieties of surgeries and about 130,000 farmers had a heart operation. All this was done with 11 cents per month. Poor people in isolation are very weak, but together they're very strong.

Robbie, we have nearly 900 million mobile phone subscribers who spend about 500 rupees per month just to speak on a mobile phone. If we can ask them to contribute 100 rupees per month for a health insurance through the mobile phone subscription, we can cover most of the healthcare costs, especially catastrophic illnesses, we can cover for one billion people, it is possible. And technology is bringing people together, cooperative society brought all the farmers together, mobile phone companies have brought all the common people together. So it's a excellent opportunity we have to launch a health insurance.

Robert Pearl: For listeners, we're not even talking about the basic operations. My remembrance is that you did implantable defibrillators, one of the most sophisticated operations. And I know, because I visited you in India, I saw a heart transplant patient, that the most complex patients were still offered the idea that because you're poor, you don't get to have the sophisticated care that others do, was simply not something that you saw as being acceptable, as being ethical. And you offered the same exact care to these poor farmers, that you would've provided to your family and to your friends. And I just think in retrospect, that was amazing. So let's look at another rule, which is that if you travel around the world, nurses are trained the same type of way, whether you're looking in North America, whether you're looking in Europe, whether you're looking in Asia. You train nurses in a very different way. Tell listeners how you did that, how you broke that rule about the quote, right way to train a nurse.

Devi Shetty: Robbie, first of all, we are living in an amazing country which supports innovation and supports a new way of doing things. I have no doubt that within the next five to 10 years time, India will become the first country in the world to dissociate healthcare from affluence. India will prove to the world that the wealth of the nation has nothing to do with the quality of healthcare its citizens can enjoy. I have no doubt about it. So we are privileged in the sense we have a large heart hospital, which is currently doing about 35 to 40 heart surgeries every day. We have about 22 operating rooms running for 12, 16 hours a day. You can imagine the number of nurses who are required to assist us for a heart operation. As you know, heart operation is a long operation, delicate operation, every surgery, heart surgery is different.

So we get young nurses, we used to train them, but within one or two years, because our hospital is accredited by Joint Commission of US, they get trained in that format, so they can walk into any of the hospitals in Middle East or other countries, and get maybe five times, 10 times higher salary than what we can pay. So we were struggling because every time a new nurse comes, we had to teach her and it's a matter of time before she leaves. So we decided to take young girls who applied for a nursing college, but they couldn't admit themselves because they come from a poor family, their parents couldn't afford the nursing education. So we took them on a training program called, Critical Care Assistant, CCA. The idea is that these girls will be trained to assist for a heart operation. Takes three years.

So they assist the nurses and learn, and within two years, Robbie, you can't believe, these nurses, when they finish three year, they become independent assistants. And today, when I'm operating, a lot of the time surgeons, we don't think, if I put my hand forward, I ask my scrub nurse, saying that, "Give me a 6.0 Prolene, that girl knows that the step of the operation I'm in, I don't need 6.0, I need 7.0. She will give me 7.0, but she won't say anything. She gives me what I need, rather than what I ask for. This is the level of passion, expertise, knowledge they have in that narrow area of heart surgery. If she's the best, nobody can compete with her. But if I take her out from the heart operation theater to a neurosurgery operation theater or a GI surgery, she'll be lost, she won't know what to do. So essentially we realized that people should be trained for a particular task and they do it from morning to evening, and they will do an amazing job and no highly qualified person can compete with them.

Robert Pearl: I believe, and correct me if I'm wrong, that on the white coat that you wear when you walk around the hospital and as you said, you see dozens and dozens and dozens of patients every day and operate, so you're wearing a white coat frequently, you have Devi, not Dr. Shetty, listed there. The norm is that physicians want to have the highest status and you're putting, you're the director of this hospital, you're the lead surgeon, just your first name. Why do you do that?

Devi Shetty: When you work in a specialized hospital, Robbie, you realize that the director's role and the person who's cleaning the floor of the operating room, there is really no big difference, because somebody not doing the job properly can effectively result in some innocent person's death. So we are all doing very, very important job, so there is no time we should think that I'm the person doing the most complicated job. I may do the most complicated job very effectively, but if the patient ends up having an infection, the result is disastrous. And it is these people at the low level who are cleaning the floor, the people who work like scrub nurses, who take care of the patient in the ICU, they're as important as me. So it is like the strength of the chain is dependent on the weakest link. So we are very clear that we are all doing the job of equal importance, nobody is doing something more important than the other.

Robert Pearl: The rule in the United States and in Europe and in Asia, is that you buy your supplies, the gowns that you wear, from a named company that manufactures them. You decided to make your own gowns in India. How did you decide to do that? How did you decide to break that rule?

Devi Shetty: We were using cloth gowns like used to use in US maybe 30 years ago. The problem of cloth gown is after every heart operation, the cloth gets drenched with blood, sterilization, drying, it's a huge task. So we wanted to go for disposables. At that time there was no company in India making disposable gowns and drapes. We were importing the disposable gowns and it was very, very expensive. And we tried to negotiate, we wanted to pay them about, I think about 3,000 or 5,000 rupees per heart operation. That's a contract we gave them and they refused. Then we told them that you get huge percentage

of the Indian market, we'll buy for all hospitals. That also didn't change their mind. Then we analyzed where is the material for the disposable gowns and drapes are made. There is a French company which makes those materials, and we decided to get our young entrepreneurs from Bangalore to start a company called Amaryllis. This started around, I think 12, 15 years ago.

And they got the material from that French company and we have large number of young girls who can stitch anything. Some of the most beautiful suits which Americans, Europeans wear today is stitched by these people living in India. So we have large number of people who can do this job, so we started the company called Amaryllis, and they gave us the disposable gowns and drapes for each heart operation for 800 rupees. That is a huge cost. And this company, during the COVID time, they were supplying drapes and gowns to the entire virtually huge part of the country. So essentially we need to really look at out of the box solution, Robbie. We have many problems in healthcare and when we try to come up with the solution, first thing we tell ourselves that we want to do this but we have no money, because we realize if you have lots of money in the bank, Robbie, your brain stops working.

Robert Pearl: You told me at one point, I don't know if it's still 100% true, but it's probably still the overall way that you approach the issue, is that you hire almost only women to work in your hospital, for the jobs that need to be required at the entry level and then up the chain until you get to the actual surgeons, who are obviously dependent upon the other institutions that train. Why did you decide to hire all or almost all women?

Devi Shetty: When we started our company around 20 years ago, we are a relatively small company with few thousand employees, nearly 90% of the employees were women. All the housekeeping staff were women, the ambulance drivers were women, which is very rare in India, our security guards were women. Whenever it was possible, we gave the jobs to the women. There is a reason, Robbie. When I used to work in Kolkata, we did a very informal study. If I have the job of cleaning the floor and I give the job to the man and give him say, 12,000 rupees per month, he will spend 6,000 rupees on himself and the remaining 6,000 rupees goes to the family's welfare. Instead of him, if I give the job to his wife and give her 12,000 rupee salary, she will spend the entire 12,000 rupees on the family's welfare, on the children and the house and everything.

And a woman who comes from a lower socioeconomic strata, from a poor family, if she's employed, she becomes an empowered woman. She's no more a doormat, she's empowered, she becomes assertive and she will discipline the children and teach them the art of making choices. If you look around the world, Robbie, why some people make right choices all the time and some people keep on making mistakes and they're never able to come out of the poverty because when they were children, their mothers were weak, they were like doormats and they couldn't discipline the children, teach them the art of making choices. So if you want to see a better world, we need to give employment for women from lower socioeconomic strata and empower them, and these women will

bring up confident children who will change the world. So this is the investment we have to make to change the world.

Jeremy Corr: Devi, as I told you before we recorded, you're one of my favorite people that I've probably ever talked to on a podcast, because you consistently blow my mind with the things you say. Some of the stuff you have done in your career for the good of the less fortunate and to make care more affordable are so amazing, that honestly they're almost hard to believe for someone who's had to regularly deal with American medicine. When you were earlier in your career and started to implement some of your ideas around free heart surgery for poor children or even focusing on hiring primarily women, what kind of pushback did you get about how realistic your ideas were and what did you do to convince people to buy into and believe in your mission?

Devi Shetty: It's very interesting, in healthcare industry, especially in country like India, the moment you start talking about the poor people, people who are not in a privileged position and you want to make a difference, there is very little resistance. If I start talking to them about maximizing profit or these areas, I'm sure there'll be a lot of resistance. But generally in our societies, when you talk about making a difference to the underprivileged, there is very little resistance. This is in my experience.

Robert Pearl: About a decade ago you opened a heart surgery center in the Grand Cayman Islands. For listeners who haven't been there, it's a gorgeous location, white sand beach. For people who have not been there, it actually has a economic cost as a tourist destination similar to the US. And there, you're doing the same superb cardiac surgery with incredible outcomes, as well as a lot of other procedures, not for $1,800 a day, but for less than half of what it costs in the United States. Why did you go to the Grand Cayman Islands and what do you see happening in that facility that you built into the future that's different than hospitals elsewhere in the world?

Devi Shetty: We have developed a very interesting model of delivering healthcare and we believe we have an obligation to show to the world that there are different ways of delivering healthcare, and this is our model. Hopefully some people will copy, some people will do better than us. In the end, there is a new way of doing and if we want to change the world, we have to do things differently. Einstein's definition of stupidity is you keep on doing the same thing over and over, but expect different results, that doesn't happen. So Cayman Island gave us a phenomenal opportunity, the government is always very, very supportive, they really went out of their way to ensure that our organization blossoms, and we have created a very successful model. And one reason why we wanted to go to Cayman Islands, we believe that the digitization of healthcare will dramatically change every aspect of standard healthcare delivery.

Every industry in the world, Robbie, is disrupted by digitization. Our banking system is dramatically changed by digitization. Today there is no way you can run a bank with paper and a pen. Our entire retail industry is disrupted by

digitization. Every industry today, the automobile industry disrupted, virtually every industry is disrupted by digitization. Healthcare is the only industry which has defied a digitization. And the software, what we have developed costing millions of dollars, has only changed the way things are done from the paper to the laptop, but they haven't added any intelligence to it, it was not built on a mobile platform. So we have created a software which is built on a mobile platform because when you're developing a tool for doctors, Robbie, if you develop it for the desktop, you will not get doctors attention. Doctors look at the laptop or a desktop five to six times in a day. They look at the mobile phone 200 times in a day.

So we decided to build the entire, our electronic medical records on a mobile platform and this is what we are using in Cayman. God willing, another six months time, one years time, it'll be mature, then we want the US hospital executives to come and see. Maybe one day it'll make some difference to delivering healthcare.

Robert Pearl: Without doubt, if you could make the electronic health record and the other components of technology focus on clinical care rather than billing and coding, you will not only improve patient care in the United States, but the tremendous amount of physician burnout, that the tools that are so clunky and poorly designed are inflicting on doctors today. So I can assure you, Devi, that all of American physicians will be cheering you on as you complete that journey and be very interested in seeing the tools that you will have created.

Devi Shetty: Thanks. Thanks, Robbie.

Robert Pearl: When I visited you in the Cayman Islands, I was impressed that the first room we came to had two large, huge screens, one of which was linked to the doctors in India, recognizing that with a 12 hour time zone difference, you could leverage the expertise in India to provide care to the patients in the Cayman's, and 12 hours later, use the expertise in the Cayman's to provide assistance in India. Thought that was truly innovative and effective. But what really impressed me was the other screen. So the rule in the United States says you get great care 24 by seven, the reality is it's not true. If you have a problem in the late evening or across the night, and by a problem, I'm not talking about a heart arrest, I'm talking about blood pressure dropping, but not yet being totally life-threatening or bleeding following surgery or oxygen dropping.

I'm going to estimate that in most hospitals, by the time the doctor does something to intervene, to address the problem, it's at least an hour. And if my memory is correct, you have this screen that first of all makes it very visible, how long it took last night, immediate data, and you're down to something like six or eight minutes. How'd you break this rule? Doctors hide the shortcomings and the failures, you make it totally visible on a huge screen and you make everyone accountable. How did you decide to break that rule and what's been the outcome?

Devi Shetty: Robbie, in India, in the US or in Europe, a patient in the critical care unit gets the best care between 9:00 AM and 5:00 PM. All the senior doctors, all the senior nurses, everyone is there during that time. For 16 hours of 24 hour cycle, patient in India, US, Europe gets sub optimal care. There are critical care units in England, at night there is no intensivist. So the reason why we thought this has to be disrupted is because if you look at the critical care services, we believe today, when you talk about a ICU bed, Robbie, only 10%, 20% of the hospital beds are critical care beds. In other 10 years time, more than half of the hospital beds will be critical care beds. Ward and room beds are going to disappear because all the things what you're doing in ward and room will be done at home, online. Now, this massive shift, if it has to happen, we need large number of intensivists. And intensivist job is not very attractive for young doctors who are graduating, because everyone wants good work-life balance, no one wants to do night duties.

So we came up with a concept that in the ICU, if you really look at the job of an intensivist, there are two types of jobs. One is thinking, analytic job of a senior intensivist, looking at the data and finding out what is going wrong and planning the treatment. Other job is actually doing, that is putting a center line, putting artery line, intubating the patient or adjusting the ventilator. These things, we don't need very senior, expert intensivist, any young intensivist can do the job, as long as somebody with the knowledge is monitoring the patient remotely. So we split the job of intensivist into two, one is people who are doing the job, because one question a lot of people may ask, if the intensivist is at home, he's not able to touch the patient, he doesn't know what is happening. We have a policy in our ICU, doctors cannot touch the patient.

Only the doctor is going to do the procedure on the patient can touch the patient, because if you touch the patient, strong possibility you may give him the infection or you may get the infection which you will spread to other patients. So the touch is not important in the ICU. Now if you split the 16 hours of poor care into two or three hour slot, and tell the intensivist that, okay, five o'clock you go home, but every third day or fourth day, just give us two or three or four hours, sitting at home, sitting in your drawing room with a cup of tea in hand, go through the data, you can see the patient in your mobile phone, and you advise the nurse or anesthetist, whoever is there, as what is going on and what needs to be done. If we can do that, we can bring down the mortality, morbidity in the critical care unit significantly, because we all know, Robbie, there is nothing like a sudden cardiac arrest.

Before the so-called sudden cardiac happens, patients start, at least six hours before, patients start getting restless, heart rate starts going up, central venous pressure start going up, urine output will go down, blood gas will deteriorate, all these things will happen. And at that time, if somebody is sitting at home monitoring the data, they're comfortably in their drawing room, they will be in a much better position to diagnose this, rather than a intensivist who spent the whole night with the patient, and at four o'clock in the morning he's looking at this patient, there is no way his brain will be able to decipher all this complex

data. So this is our strategy, that the thinking intensivist after five o'clock should be at home, working only few hours, third night or a fourth night, and that will be a game changer in delivering healthcare. This is what we are trying to do in Cayman, in India and all over the place.

Jeremy Corr: When you started Health City Cayman, where you're offering heart surgery for a fraction of the cost of what it is in the United States, yet with the same or even better outcomes, did many of your American patients talk about what their doctors in the US said when they tell them that they're going to Grand Cayman to get their surgery instead of the health system where they're used to going for care? Are they given any negative stereotypes such as not receiving as good a care or as outcomes as they would in the United States? Do you think any potential pushback would be based on the patient's home system potentially losing out on significant revenues from not doing the surgery themselves?

Devi Shetty: Interestingly, we do not get that many patients from US, but surprisingly the doctors in US are very open for these changes and we haven't come across any negative comments from any of the doctor. We are very, very small compared to what the US hospitals and the doctors have, maybe that's a reason, but generally we haven't yet experienced any of the negative cynical views on what we are doing.

Robert Pearl: One last question, Devi. We've probably talked about a dozen rules that you have broken effectively, with world leading outcomes, probably if we had more time, we could talk about two dozen more that you've already accomplished. What's next?

Devi Shetty: We would like the nurses working in the ward to regain the joy of taking care of the patients. That is the project we are working on. Nurses across the world working in the ward, really don't enjoy the job. Just look at their job, Robbie. They come for work, say at seven o'clock in the morning, take one BP operators and go from one bed to the other bed, checking the blood pressure, checking the pulse rate, checking the respiratory rate, temperature, and they write it down on a piece of paper. That takes about 15 minutes. If the ward has 30 patients, by the time they finish recording the vitals for 30 patients, it is a time for her to go back and start doing all over again. It is the most boring, mundane job. Now, if the nurse is on duty at night, 12 o'clock at night, when she goes to the bedside and she wants to check the blood pressure, first thing what happens is patients start screaming at the nurse because she has woken him up and he won't be able to get back to sleep.

This happens every time in India, it happens in US, in England. So what do nurses do? At night, they bluff. They write that they have recorded the blood pressure, they haven't because they can't. We have created an environment for them to lie. And maximum number of cardiac arrest in hospital happen around four o'clock, five o'clock in the morning because that is a time they wouldn't have been monitored. Just think about, you just put one easy patch on the chest wall, it gives continuous monitoring of the ECG with the analytics, it gives the

temperature, it gives a saturation, it gives a respiratory rate, it tells you if the patient is restless and it's real time. So in front of the nurse's station, there is a TV with the patient's name and the room number, with three colored flags, green color flag, orange and red color flag.

And when things go wrong, something is going wrong like a pulse rate is going up or a blood pressure going down or whatever, it changes to orange or red, depending on the seriousness. Analytics tool can develop that, and they only go to see what is wrong with the patient. That is a job, it is interesting for the nurse. She's going there as a person to investigate and help the patient, not getting the data from the patient. If we do that, I am very, very sure that we can virtually eliminate cardiac arrest happening in the ward and we will bring back the joy of taking care of the patient by the nurses. We have seen, Robbie, 65% of the nurse's time is spent in recording what is going on. It is stupid, we have to change. What is coming in the cardiac monitor, they again enter into the system or they write it down. Why can't we have a system where the data come directly from the cardiac monitor into this EMR? These are the basic things which has happened in every industry. How long we are going to remain as an exception?

Jeremy Corr: You're one of the most prolific and respected rule breakers in medicine in the entire world. After your career is over and after you pass from this world, what is the legacy you want to leave behind and what do you want to be remembered for most? I also kind of wonder what you're doing to inspire and encourage the next generation of rule breakers who will continue to push and break the boundaries of medicine long after you're gone?

Devi Shetty: So Jeremy, I'm convinced that when you strive to work for a purpose which is not about profiting yourself or your own personal interest, if the purpose of our action is to help the society, mankind on a large scale, cosmic forces ensure that all the required components come in place and your dream comes a reality. I have no doubt about it. I have noticed this so many times. Whatever we could do in India, if you really sit back and analyze it scientifically, lot of things couldn't have been done, but it happens mainly because of the impact which is going to touch millions of people. I strongly believe that my country will dissociate healthcare from affluence. My country will prove to the world that wealth of the nation has nothing to do with the quality of healthcare its citizens can enjoy.

Robert Pearl: Devi, you are an inspiration. You're telling me always, across the time I've known you, what the future is going to look like. And unlike some people who talk about what could be, you make it a reality. Keep up the great work Devi, and I can't wait to hear about the success of all your programs.

Devi Shetty: Thanks. Thanks, Robbie. Thanks, Jeremy. Thank you, most grateful.

Jeremy Corr: Robbie, what do you think about what Dr. Shetty said?

Robert Pearl: Jeremy, Devi is one of the most strategic and brilliant individuals I have ever met. He's dedicated to his patients and committed to making healthcare available to people around the globe, regardless of their economic status. He inspires me every time I hear him speak. In the United States today, with resources that are 10 times greater than what he has in India, we say the medical care we provide is the best we can do given the limited dollars we have. Devi has shown how short-sighted that view is. Although so far, few Americans have traveled to the Grand Cayman Islands for their surgery, I can see that possibility in the future. As healthcare costs rise faster than people and businesses can afford, change will happen. It could come from inside our nation, led by the Amazon's, CVS's and Walmart's of the retail world, or it could come from visionaries like Dr. Shetty and his hospital in the Caribbean.

But anyone who thinks that the broken system of today will last indefinitely, they're in denial. And given Dr. Shetty's superior clinical outcomes and sophisticated information technology, many of the Americans who choose to get their care from him and his team in the future, will do so for the higher quality, not just the dramatically greater affordability. Hopefully American doctors and hospitals will awaken before it is too late.

Jeremy Corr: We hope you enjoyed this podcast and will tell your friends and colleagues about it. Please follow Fixing Healthcare on Apple Podcasts or your favorite podcast platform. If you like the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com and follow us on LinkedIn, Facebook, and Twitter, @fixinghcpodcast. Thank you for listening to Fixing Healthcare, Breaking the Rules, with Dr. Robert Pearl and Jeremy Corr. Have a great day.