

University of Chicago Pritzker School of Medicine commencement address
“Money”
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Thank you to the students and to the Dean for inviting me here to participate in your graduation. It is an honor.

I want to tell you the story of a friend I lost to lung cancer this year. Jerry Sternin was a professor of nutrition at Tufts University, and with his wife Monique, he'd spent much of his career trying to reduce hunger and starvation in the world. He was for awhile the director of a Save the Children program to reduce malnutrition in poor Vietnamese villages. The usual methods involved bringing in outside experts to analyze the situation followed by food and agriculture techniques from elsewhere.

The program, however, had itself become starved—of money. It couldn't afford the usual approach. The Sternins had to find different solutions with the resources at hand.

So this is what they decided to do. They went to villages in trouble and got the villagers to help them identify who among them had the best-nourished children—who among them had demonstrated what Jerry Sternin termed a “positive deviance” from the norm. The villagers then visited those mothers at home to see exactly what they were doing.

Just that was revolutionary. The villagers discovered that there were well-nourished children among them, despite the poverty, and that those children's mothers were breaking with the locally accepted wisdom in all sorts of ways—feeding their children even when they had diarrhea; giving them several small feedings each day rather than one or two big ones; adding sweet potato greens to the children's rice despite its being considered a low-class food. The ideas spread and took hold. The program measured the results and posted them in the villages for all to see. In two years, malnutrition dropped 65 to 85 percent in every village the Sternins had been to. Their program proved in fact *more* effective than outside experts were.

I tell you this story because we are now that village. Our country is in trouble. We are in the midst of an economic meltdown like nothing we've seen in more than half a century. The unemployment rate has passed nine percent. For young people ages 25 to 34, the rate is approaching eleven percent. Our auto industry has filed for bankruptcy. Our housing and finance industries are shadows of their former selves. Our state and local governments are laying off teachers and municipal workers.

It is worth reflecting on how extraordinarily lucky we who are doctors, or doctors-to-momentarily-be, are. Consider the contrast between what every other

graduation ceremony taking place today must feel like—the graduation ceremonies for the undergraduates, the business school students, the law school students, the architects, the teachers—and what ours does. There are thousands graduating proudly today but fearing for their future. Many have no jobs, no sense of how they'll make it.

We doctors meanwhile remain with no significant unemployment. Virtually all of us can find gratifying and well-compensated work in our chosen fields, and that is remarkable. It is something to be deeply thankful for.

Yet the idea that we can proceed oblivious to the economic conditions around us is folly. In fact, it is not just folly. It is dangerous.

Job losses and cutbacks have produced an unprecedented increase in the uninsured. Half of hospitals were already operating at a loss before the economy tanked, and the rise in patients who cannot pay their medical bills have since pushed many into insolvency. Hospital closures and layoffs have started, as you know all too well in Chicago. We *will* be affected by what is going on in our country.

More than that, though, we in medicine have partly contributed to these troubles. Our country's health care is by far the most expensive in the world. It now consumes more than one of every six dollars we earn. The financial burden has damaged the global competitiveness of American businesses and bankrupted millions of families, even those with insurance. It's also devouring our government at every level—squeezing out investments in education, our infrastructure, energy development, our future.

As President Obama recently said, "The greatest threat to America's fiscal health is not Social Security, though that's a significant challenge. It's not the investments that we've made to rescue our economy during this crisis. By a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care. It's not even close."

Like the malnourished villagers, we are in trouble. But the public doesn't know what do about it. The government doesn't know. The insurance companies don't know.

They brought in experts who explained that a quarter of our higher costs is from having higher insurance administration costs than other countries and higher physician and nurse pay, too. The vast majority of extra spending, however, is for the tests, procedures, specialist visits, and treatments we order for our patients. More than anything, the evidence shows, we simply do more expensive stuff for patients than any other country in the world.

So the country is now coming to us who do this work in medicine. And they are asking us, how do they get these costs under control? What can they do to change things for the better?

It is tempting to shrug our shoulders. It is tempting to say this is just the way good medicine is. But we'd be ignoring the evidence otherwise. For health care is not practiced the same way across the country. Annual Medicare spending varies by more than double, for instance, from less than \$6000 per person in some cities to more than \$12000 per person in others. I visited a place recently where Medicare spends more on health care than the average person earns.

You would expect some variation based on labor and living costs and the health of the population. But as you look between cities of similar circumstances, between places like McAllen and El Paso, Texas, just a few hundred miles apart, you will still find up to two-fold cost differences. A recent study of New York and Los Angeles hospitals found that even *within* cities, Medicare's costs for patients of identical life expectancy differ by as much as double depending on which hospital and physicians they go to.

Yet studies find that in high-cost places—where doctors order more frequent tests and procedures, more specialist visits, more hospital admissions than the average—the patients do no better, whether measured in terms of survival, ability to function, or satisfaction with care. If anything, they seemed to do worse.

Nothing in medicine is without risks, it turns out. Complications can arise from hospital stays, drugs, procedures, and tests, and when they are of marginal value the harm can outweigh the benefit. To make matters worse, high-cost communities appear to do the low-cost, low-profit stuff—like providing preventive care measures, hospice for the dying, and ready access to a primary care doctor—LESS consistently for their patients. The patients get more stuff, but not necessarily more of what they need.

Fixing this problem can feel dishearteningly complex. Across the country, we have to change skewed incentives that reward quantity over quality, and that reward narrowly specialized individuals, instead of teams that make sure nothing falls between the cracks for patients and resources are not misused. President Obama, I'm pleased to say, committed to making this possible in his reform plan to provide coverage for everyone. But how do we do it?

Well, let us think about this problem the way Jerry Sternin thought about that starving village in Vietnam. Let us look for the positive deviants.

This is an approach we're actually familiar with in medicine. In surgery, for instance, I know that I have more I can learn in mastering the operations I do. So what does a surgeon like me do? We look to those who are unusually successful—the positive deviants. We watch them operate and learn their tricks, the moves they make that we can take home.

Likewise, when it comes to medical costs and quality, we should look to our positive deviants. They are the low-cost, high-quality institutions like the Mayo Clinic; the Geisinger Health System in rural Pennsylvania; Intermountain Health Care in Salt Lake City. They are in low-cost, high-quality cities like Seattle, Washington; Durham, North Carolina; and Grand Junction, Colorado. Indeed, you can find positive deviants in pockets of most medical communities that are right now delivering higher value health care than everyone else.

We know too little about these positive deviants. We need an entire nationwide project to understand how they do what they do—how they make it possible to withstand incentives to either overtreat or undertreat—and spread those lessons elsewhere.

I have visited some of these places and met some of these doctors. And one of their lessons is that although the solutions to our health cost problems are hard, there *are* solutions. They lie in producing creative ways to insure we serve our patients more than our revenues. And, it seems that we in medicine are the ones who have to make this happen.

Here are some specifics I have observed. First, the positive deviants have found ways to resist the tendency built into every financial incentive in our system to see patients as a revenue stream. These are not the doctors who instruct their secretary to have patients calling with follow-up questions schedule an office visit because insurers don't pay for phone calls. These are not the doctors who direct patients to their side-business doing Botox injections for cash or to the imaging center that they own. They do not focus, the way business people do, on maximizing their high-margin work and minimizing their low-margin work.

Yet the positive deviants do not seem to ignore the money, either. Many physicians do and I think I am one of them. We try to remain oblivious to the thousands of dollars flowing through our prescription pens. There's nothing especially awful about that. We keep up with the latest technologies and medications in their specialty. We see their patients. We make our recommendations. We send out our bills. And, as long as the numbers come out all right at the end of each month, we put the money out of their minds. But we do not work to insure we and our local medical community are not overtreating or undertreating. We may be fine doctors. But we are not the positive deviants.

Instead, the positive deviants are the ones who pursue this work. And they seem to do so in small ways and large. They join with their colleagues to install electronic health records, and look for ways to provide easier phone and e-mail access, or offer expanded hours. They hire an extra nurse to monitor diabetic patients more closely, and to make sure that patients don't miss their mammograms and pap smears or their cancer follow-up. They think about how to create the local structures and incentives to make better, safer, more appropriate care possible.

I recently heard from one such positive deviant. He is a physician here in Chicago. He'd invested in an imaging center with his colleagues. But they found they were losing money. They had a meeting about what to do just a few weeks ago. The answer, they realized, was to order more imaging for their patients—to push the indications where they could. When he realized what he was being drawn to do by the structure he was in, he pulled out. He lost money. He angered his partners. But it was the right thing to do.

I met another positive deviant, a thoracic surgeon named Dr. Mathew Ninan who joined a group of pulmonologists, surgeons, and oncologists in Memphis to change the quality of care for lung cancer patients in their city. “Our approach is simple,” he told me. “We will see every patient regardless of insurance status. We will make every attempt to see patients jointly in one visit. We will discuss every new patient that we see in a multi-disciplinary format on the same day and decide on a plan of treatment. We will follow every patient to track whether they receive the right treatment. And we will enroll as many patients as we can in clinical trials dedicated to improving lung cancer care.”

To insure that unnecessary costs are avoided, they took yet further steps. The toughest was that the surgeons agreed to do no operations on lung cancer patients unless the pulmonologist and oncologist agree that it is indicated. This is radical. “I have had to swallow my ego repeatedly to stick to this principle,” he said. Sometimes he's had to persuade them an operation was best. More often, however, they persuade him to drop his plan and with it the revenue. But he did—because it was the right thing to do.

No one talks to you about money in medical school, or how decisions are really made. That may be because we've not thought carefully about what we really believe about money and how decisions *should* be made. But as you look across the spectrum of health care in the United States—across the almost threefold difference in the costs of care—you come to realize that we are witnessing a battle for the soul of American medicine. And as you become doctors today, I want you to know that you are our hope for how this battle will play out.

As you head into training and then further onward into practice, you will be allowed into people's lives in a way that no one else in society is permitted. You will see amazing things. And you will develop extraordinary abilities.

Along the way, you will sometimes feel worn down and your cynicism taking over. But resist. Look for those in your community who are making health care better, safer, and less costly. Pay attention to them. Learn how they do it. And join with them.

If you serve the needs of your patients, if you work to ensure that both overtreatment and undertreatment are avoided, you will save your patients. You will also save our country. You are our hope. We thank you.