

### 3 Takeaways Podcast Transcript

Lynn Thoman

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#### Ep. 182: The One And Only Dr. Atul Gawande In An Eye-Opening, Wide-Ranging Talk About Global Health

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**INTRO male voice:** Welcome to the 3 Takeaways Podcast, which features short memorable conversations with the world's best thinkers, business leaders, writers, politicians, scientists, and other newsmakers. Each episode ends with the three key takeaways that person has learned over their lives and their careers. And now your host and board member of schools at Harvard, Princeton, and Colombia, Lynn Thoman.

**Lynn Thoman:** Hi everyone, it's Lynn Thoman. Welcome to another 3 Takeaways episode. Today, I'm excited to be with Atul Gawande. Atul is legendary in the field of healthcare. He's a renowned surgeon and a professor at Harvard Medical School, and the Harvard Chan School of Public Health. He's also an author who's written four bestselling books, which have revolutionized healthcare. His books include *Complications: A Surgeon's Notes on an Imperfect Science*, *The Checklist Manifesto*, and *Being Mortal: Medicine and What Matters in the End*. Dr. Gawande is an expert at improving health outcomes and scaling health solutions. Just one of his ideas, his checklist for operating rooms, has reduced surgical deaths in hospitals around the world from 30 to 50%. At present, he's leading global health at USAID, which includes over 2,500 people in over 60 offices around the world.

**LT:** A 100 years ago, improving global health would've been much more difficult, if not impossible. What's so exciting today is that we've discovered how to address many of the health needs in the world in substantial ways that are also economically doable. I'm excited to find out more about improving health outcomes for both people in developing and also wealthy countries. Welcome, Atul, and thank you for your work to improve healthcare, and thank you also for joining 3 Takeaways today.

**Atul Gawande:** I'm delighted to be here. Thank you.

**LT:** It is my pleasure. Your life was very busy as a surgeon, as a professor, and as a writer for the *New Yorker*, and author of four bestselling books. Why did you take the job of leading global health for USAID?

**AG:** Well, I've been fascinated from the very beginning, from writing, from my practice in medicine, and in my public health work, with this core question. We have doubled the human lifespan over the course of the last century. We're trying to figure out how to enable that capability not just for a select minority of the world but for every person alive. And I've argued, it's the most ambitious endeavor human beings have ever attempted. It is 19,000 drugs that are now approved that we're trying to deploy. It is 4,000 medical and surgical procedures, and it's over 1,000 public health interventions. USAID, you mentioned the footprint, we are responsible for everything from the goal of eliminating HIV as a public health threat, for eliminating TB and malaria as public health threats, for eradicating polio, for safeguarding the United States against health threats from

abroad.

**AG:** And when I was asked to do this, we were in the middle of the COVID pandemic. And the opportunity was to be in a place where we're actually scaling at an incredible reach in a way that I've never had an opportunity to do directly in the work I've been doing. And it also is a chance to learn from many places that are struggling and some places that are getting incredible results, that I actually think we could learn a lot from in the United States.

**LT:** Many people think about global health as improving health in the poorer countries. Can you talk more about how you think about it?

**AG:** I think that this frame, that we are learning as a generation how to enable the 80-plus year lifespan that is available to the top-performing countries in the world, and they're often the wealthiest, but no longer only those, as what global health is. It's not just about the poorest, it's about every country having gaps. In the United States, the top 1% of income live more than 87 years on average and the bottom 1% of income live 72 years of life on average. That was before the pandemic. And the pandemic exacerbated inequities even more. So the differences within countries can be as large as the differences between countries. Solving the ability to deliver lifelong health, and long lives, is what I think of as global health. It is true, for many people, global health is about the poorest, but I think every country is actually on this journey. None of us have completely figured it all out.

**LT:** You've identified complexity as one of the key issues of the 21st century. Can you talk about complexity and healthcare?

**AG:** I think of complexity as fundamentally a question of, how do we deliver on the knowledge that we have discovered about how to save lives? We human beings lived in a world where our lives were largely governed by ignorance. We didn't understand the forces that were governing our lives and our societies, let alone what to do about them. Now, we have solutions, but driving them to scale is extraordinarily complex - it's human beings and how we interact with one another. It can be as simple as and as complex as, how does a clinician and a patient sitting across from one another maneuver and manage all of the art and science of health and public health available to us and make it work? That is the fascinating and fundamental complexity. They are trying to access the assets of thousands of drugs, an enormous volume of knowledge, navigate a ton of uncertainty, and arrive at ways that they together are going to work on delivering a better outcome for a person, according to what matters most to them. You can write novels about this. And also spend a whole career trying to make that interaction succeed.

**LT:** You mentioned other countries. In fact, Thailand, Portugal, Chile, Costa Rica, Ecuador and Panama all have higher life expectancy than the US. And Chile and Costa Rica have tied with Canada in having the highest life expectancy in North and South America. How do poor and diverse countries in Asia, Europe, and South America have such outstanding health outcomes?

**AG:** Well, one thing to remember is they didn't - they did not 30 years ago, 40 years ago have those kinds of results. And interestingly, the US, through USAID, our international development agency, has supported countries on this journey. And there's scores of countries that we've supported to advance in their development. And each has been an experiment, and now we're seeing some of the results. Thailand is a great example. They put the majority of their funds that they had for support

and development, into building community-based primary care. What do I mean by that? Meaning that in your local community, they prioritized, more than building out more hospitals, was having a local clinic with at least a “nurse level” who could address acute needs and prevention and chronic care. And they have outreach workers, community health workers who would go door to door and make sure that people who were not accessing that system got critical education about how to address their health, brought them into the system and accompanied them to make sure that, if they had HIV, that they were being tested, they were being treated, that they weren't being lost to following through on what they needed.

**AG:** And it has saved lives. A country like Thailand that was nowhere near US life expectancy, now on \$300 per person per year with a strong primary care base, are delivering a 79-year life expectancy, on their way to over 80 years, while we're at \$13,000 per year and don't have that capability to pull people who are lost in the system into getting the care that they needed.

**LT:** So there's an opportunity to learn both ways, from the poorer countries to the wealthier countries, and vice versa?

**AG:** And we did it. During COVID, we found pretty quickly that if we needed to make sure to vaccinate, offer vaccination to every person across the country, especially the people who were over 65 and had chronic illness, we would wait in hospitals and clinics to see if they showed up. They had difficulty getting appointments, they didn't know where vaccines were available, all those things. And we couldn't get to over 90%, 95%. The only way we got there, we ended up hiring over 100,000 community health workers, who were people from the community, who would go door to door and make sure people knew about the opportunity, had their needs assessed, and helped serve them. That was how we got to over 95% of the people 65 and over vaccinated.

**AG:** Democrats, Republicans, Independents, we hear all the political divides, but in fact, people got what they needed by making sure it was affordable and making sure that you actually reached out to people and made the offer.

**LT:** When you talked about some of the countries with outstanding healthcare, you talked about essentially a focus on primary care, as well as community health workers. And the US has what you call a "vertical healthcare system" or more of a vertical healthcare system. Can you talk about that and how well you think it's working in the US in today's world of complexity?

**AG:** In order to navigate that complexity I described earlier of what you need at any stage of your life to access all the assets in the system, we essentially say, "You as an individual are responsible for figuring it all out." And there is no navigation, no support for enabling that to happen. And we get terrible results from that. Our biggest killer in the country is cardiovascular disease. Under 50% of people who have high blood pressure, the biggest source of cardiovascular disease, under half of them have their high blood pressure recognized and are receiving the right medications to have it under control. Places that support them, with not just a great smart doctor or nurse to get the right plan, but an outreach worker of some kind – in the international health space, we call them "community health workers," - but an outreach worker of some kind to follow up and check whether blood pressure is under control, to make sure that they didn't have difficulty getting their medications, to connect them back when it turns out the blood pressure is still too high and adjustments need to be made, that gets us over 90%.

**AG:** And we are losing people at every stage of life, in profound ways because we've not made that happen. You described Costa Rica or Chile, that are achieving longer life expectancy in Americas, than anywhere except Canada. And the top 20% are better off in the United States than in Costa Rica. They have longer life expectancy, but below those levels, they're better off in Costa Rica, especially if you're in the bottom 50%, because there are ways that they're connected to a clinic and outreach capability that ensures people can navigate to what they need. And it's not always perfect, it's just better.

**LT:** One of the areas that you've focused on and had enormous impact on is scaling healthcare. Can you talk about how your checklists came about and where you see opportunities to scale and improve healthcare now?

**AG:** I've been very motivated by trying to identify, "What are the biggest opportunities to improve results and save lives?" And in surgery is high risk, and mistakes happen, and teams can underperform. And we borrowed a lesson from the aviation industry and said, "Let's make the equivalent of a pilot's checklist for the operating room." Ended up being a checklist where there's a less than 60-second check when the patient arrives in the room, another check before the incision is made, and another set of checks before the person leaves.

**AG:** Some of it's about dumb stuff. Do you have the right side of the body? Do you have the right person? Are you giving the right antibiotic in the right time? Did you make sure you have blood if you need it? Etcetera. But much of it is more basic communication. Is everybody aware of what the goals for the operation are, what the special medical needs of this patient is?

**AG:** And it's a script. The nursing team, the surgical team, the anesthesia team, all follow the script to inform one another about one another's plans and make sure everybody is aligned. And you'd think that always happens. It doesn't. And we proved in eight cities that it cut the death rate by 47%, deploying it in cities around the world, including in the United States.

**AG:** But then the next question is, How do you get it to scale? And that's a long story to unpack, but I'll just say I worked on marketing for a year and a half or two years. I wrote my book Checklist Manifesto. I got it on every medical television program. I even got to be part of writing a script for the television show, ER. George Clooney and Noah Carter and Noah Wyle's last episode [of ER]. And it saved Carter's life when he needed a transplant.

**AG:** But an increased awareness. Marketing can move people from pre-contemplation to contemplation. It doesn't move them to planning and execution on action. And that requires community, and a combination of things has been what has driven it around the world. One has been really learning a way that you put a team together with a surgeon, anesthesiologist, and nurse who work through the steps of introducing it in every hospital, familiarizing people with the checklist. It's like detail reps bringing it around for people to adopt. And they adopt it themselves and work through the challenges. And then when it's combined with a requirement at a national level, we get to extraordinarily high rates of adoption. It's now required by Medicare and Medicaid that these checklists are used in the United States. And we have other countries where it's rolled out around the world, with substantial reductions in mortality.

**LT:** I found it fascinating. You talked about complexity and you talked about some of the numbers, but there are about, I think you've said 70,000 different ways that the human body can fail. You

talked about 19,000 FDA approved drugs and I think there are about 4,000 approved medical procedures. We also have a high percentage of healthcare in the US, depending on whose numbers you look at, maybe 30 or 40% that is not evidence-based or based on best practices. What do you think the future of healthcare looks like? How can we improve it?

**AG:** Well, that rate is common and around the world as well. In the face of enormous complexity, we've relied a lot on the idea that if you just train longer and longer and longer until now practically half your lifespan has passed before you become a fully-fledged doctor, for example, then you're expected to have stuffed it all into your head and you can make it come out effectively. And we know that's unreliable. That's not enough. Some of the things that I've worked on like a checklist are just simple systems that make it so you've enabled a team or an individual to have a better chance of having the most critical components not missed. But then there's lots of things you can do to simply make it easier to do the right things, the nudges that make that better. And also removing barriers. Electronic medical records are both the bane of our existence and a boon to some of these efforts.

**AG:** There are too many reminders, too many alerts, and that can be managed badly in ways that lead to lower performance, but designed right, also getting the right tweaks and nudges. For example, the fact that you now get prescriptions done on computer has massively reduced errors in medication prescription and getting the doses wrong, because you don't have to memorize them and you're not deciphering illegible handwriting and scrawls and missed decimal points that lead to the wrong doses being given. It's massively reduced the medication errors just by being able to order online in a regular way. So those processes of putting systems in place are critical.

**AG:** And then the next level is where you start to be able to automate some of the practices. And we're just entering the era of AI and learning what is going to be possible. But in my role at USAID, for example, we've been deploying in seven countries so far chest X-ray systems that are read by an AI reader where radiologists are not readily available. And they match or exceed radiologist performance. So I think we're going to see in the next decade ways in which a primary physician is empowered with more intelligent capability. And it's not that AI is going to replace the physician, but as others have said, and I like this way of putting it, the physician who is able to use AI will replace the physician who does not use AI.

**LT:** Before I ask for the three takeaways you'd like to leave the audience with today, is there anything else you'd like to mention that you haven't already talked about?

**AG:** Well, the one thing I would say is that I have a set of core priorities for accomplishing what we want to accomplish. And when I came into this job, number one was making sure we addressed COVID, and we got to talk a little bit about that. Number two was that I wanted to accelerate and advance our progress on primary care to see that all our work in TB, malaria, child health, maternal health, etcetera, contribute to a larger primary care system for the reasons that we got to talk about. The third was making a stronger, more effective global health security system, so that we are better prepared for outbreaks and pandemics than we were the last time. And a ton of my work has been learning and now deploying our support of both policy at a global level, as well as support in partner countries, that strengthen their ability to recognize dangerous diseases breaking out, respond, be able to diagnose quickly, get countermeasures in place, and a rapid response that brings things under control.

**LT:** That's phenomenal. I think we're all so much more aware of global health and our

vulnerability, so thank you for that. What are the three takeaways you'd like to leave the audience with today?

**AG:** Takeaway number one is that death before 50 is now largely preventable. The focus has been on individual diseases that we now have the know-how and want to make sure that we deploy solutions for HIV, TB, malaria, death in childbirth and so on. What we now are demonstrating in countries, whether it's higher-income countries like the US and countries and parts of Europe, or even low middle-income countries like Thailand, or some of the countries you named in Latin America, we've seen incredible progress. They are getting the percentage of deaths that occur before age 50 down to 10% or less. We can, at this point, make it so less than 10% of deaths occur before you're 50. And that's an extraordinary accomplishment. We've all have had the goal that death in children should be rare, and we're making that the reality around the world, but now essentially death before middle age, we can make that uncommon. So that would be my takeaway one.

**AG:** Takeaway two is that primary care is society's scaffolding for a long life. And we've gotten to talk about that as a major takeaway.

**AG:** And I'd say takeaway number three relates to global health security and pandemic response. The world needs what I've come to think of as its own immune system. Our body's immune system will take an outbreak in our own body of an infection, and react quickly to recognize it and to mount a coordinated response that successfully contains it and prevents it from catastrophe. We now have demonstrated the pathway; the world is able to have that. Even in the lowest income parts of the world, we're seeing that there is a structure that can be enabled, that allows for clinicians at the frontline to recognize when risky, dangerous diseases, even unknown diseases, can be identified. That people can be protected, that we can deploy capability to contain the spread, and eliminate it. And we can make that more and more successful. And we in the US have made a major investment, supported by Republicans and Democrats, that has increased funding to support the world achieving these goals and to pursue diplomatically that all countries come in behind this notion that the world needs an immune system and we know how to build one.

**LT:** Thank you, Atul, this has been wonderful. And thank you for all your work to improve healthcare in the US and in the world.

**AG:** Thank you. It's great to talk to you.

**OUTRO male voice:** If you enjoyed today's episode and would like to receive the show notes or get new fresh weekly episodes, be sure to sign up for our newsletter at <https://www.3takeaways.com/> or follow us on [Instagram](#), [Twitter](#), [LinkedIn](#) and [Facebook](#). Note that 3Takeaways.com is with the number 3, 3 is not spelled out. See you soon at 3Takeaways.com (<https://www.3takeaways.com/>)

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