Unaccountable: What Hospitals Won’t Tell You
And How Transparency Can Revolutionize Healthcare
(An Interview with Dr. Martin Makary)

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola
MM: Dr. Martin Makary

Introduction:

DM: Welcome, everyone. This is Dr. Mercola, and today we are joined by Dr. Martin Makary, who is the author of a recent book that was just out late last year, called Unaccountable: What Hospitals Won’t Tell You and How Transparency Can Revolutionize Healthcare, which is a story of modern medicine’s dangerous practices and mistakes.

He is a practicing surgeon at Johns Hopkins Hospital and an associate professor of public health policy at the Johns Hopkins School of Public Health. He also has published studies on using a safety checklist in surgery.

As a busy surgeon, he’s worked in many of the best hospitals in the country, and he can testify to the amazing power of modern medicine to cure. But he’s also been a witness to the medical culture that routinely leaves surgical sponges inside patients, amputates the wrong limbs, and overdoses children because of sloppy handwriting. So, welcome and thank you for joining us today.

MM: Thank you.

DM: You have a very prominent position at Johns Hopkins Hospital. As we’ve mentioned, you’ve worked in some of the best hospitals in the country. I’m wondering what led you down this journey to write the book Unaccountable.

MM: Well, first of all, some of those examples of medical mistakes are the extreme. And unfortunately, they do happen. But you know, one in four patients in a hospital is harmed in some way from a medical mistake, according to the New England Journal of Medicine.

Now, people like you and I have been noting these things for years. And many doctors have been concerned about the quality and mistakes in healthcare. But we’re really at a very exciting time in medicine. For the first time, we’re speaking up openly and honestly about this problem. We’ve got research now that supports it.

But you know, when I was at a major medical conference once, I heard a surgeon at the podium ask the audience of thousands of doctors, “Do you know of somebody out there in practice who
should not be practicing because they are too dangerous?” And every single hand went up. Everybody seems to know about this problem. Everybody even knows of somebody who’s dangerous to be in practice. Yet for a long time, we haven’t been honest about the problem.

So, that was really the impetus to get into this area of research, to be a part of this transparency movement in medicine, and to really talk about the wide variations in care in America.

When I was a medical student, I watched a colonoscopy procedure. And one day, we discovered a polyp, and the doctor called another doctor to sort of come in. He had this ability to sort of lasso the thing and snare it out. The next day, I saw the same polyp with another doctor. I asked him, “Are we going to take it out like we did with this other doctor?” And he said, “No, I’d just like to take these out with surgery.” And it struck me that the same thing is treated in two radically different ways.

That’s the story in a lot of what I see in practicing minimally invasive surgery at Johns Hopkins. I see people coming for second opinions. They’ve been told they need big open operations when, in fact, they may need minor operations, or maybe they don’t even need surgery. Or they’ve been told surgery is too risky when, in fact, it’s safe and applicable. There are these wide variations in who gets blood transfusions. Every doctor seems to have their own threshold, even though solid medical evidence supports a set threshold.

I remember as a medical student, somebody came in to the emergency room with a fractured humerus, and the doctor said, “You need an MRI, an X-ray, and a CAT scan,” and went through this long list of tests. The poor kid said, “You know, I don’t have health insurance.” The doctor said, “What? You don’t have health insurance? Well, I’ll tell you what. Just stay off of it, and you’ll be fine.” I thought about it. And I thought, the doctor was right. All those tests don’t really change what we do, because the treatment for that type of fracture was just a sling and to rest it.

So, we see these wide variations on what we do. And when you ask the doctors, “Look, what’s going on? Why do we have so much variation in quality and safety in America?” they point out things like “Look at our perverse incentives.”

Doctors are getting crushed right now. They’re asked to see more patients within an hour. Surgeons, like myself, sometimes are under quotas. They’re told they need to do so many operations in a month. Sometimes doctors tell me they get text messages and emails, saying, “You need to do so many operations by the end of the month.” They’re expected to.

And of course, there was a recent 60 Minutes, where emergency-room doctors were under quotas to admit a certain percentage of patients they saw in the emergency department. There is pressure on doctors. There are perverse incentives. And when we talk to doctors, they’re honest about the problem. They don’t like these pressures. They want to practice medicine in a way that it was meant to be practiced – in a creative art form, where there is individualization, custom-tailored treatment, and yet standardization with the best practices.

**DM:** I couldn’t agree more. I’m drawn to the experience you had as a medical student and the emergency-room physician who changed his recommended testing process once he found out the patient didn’t have any insurance.
And just as an observation, it seems that’s really the big crux of the entire problem. Because, you know, on one hand, you have a number of physicians who are ordering tests based on a checklist that has nothing to do with figuring out what’s all the problem. They just got to rule out these bizarre [inaudible 06:23] to make sure they don’t have them. In this case, that wasn’t what’s going on.

But then you have this incentive to do these tests to increase the revenue for the hospital. And interestingly, if that patient has a more life-threatening condition like chest pain, that automatically seems to guarantee this whole new process, including admitting them to the hospital for observation, even though that patient may have had a nuclear treadmill two days prior to that visit that was negative.

And as a result, that patient is getting an enormous bill, typically 20,000, 30,000, to 50,000 dollars. If they don’t have insurance, they’re paying a rate that is double or triple of that of the person with insurance.

I mean, it’s just all these factors going to... So, I’m wondering if you could comment on that, because it seems, to me a really major issue that’s leading to the catastrophe we have in healthcare today. I mean, it’s just a major disconnect between a practical, pragmatic approach that’s really going to solve patients’ problems versus all these other variables that are thrown into the equation.

MM: Well, we’re not only learning that some doctors are under intense quotas, but also we’re learning that sometimes a computer software program will order tests and studies automatically, and the doctor just sort of has to agree to it. Doctors don’t like this. They want to practice medicine the way it was intended to be practiced – individualized in care.

But you know, one exciting thing going down right now is that the Institute of Medicine just put out a report that said what many doctors have been saying for years. And that is that up to 30 percent of everything we do in healthcare may be unnecessary. Thirty percent of all the medications, tests, and procedures that we do may be attributed to fraud, being unnecessary, and overuse.

Now, we’ve got good people. I really believe doctors go into the profession with good intentions. But we’ve got good people working in a bad system. When you put perverse incentives out there, when there’s little standardization, of course, you’re going to see widespread overuse and overtreatment. And you know what? Sometimes, I find myself doing it as a doctor, and I don’t even realize I’m doing it.

When we go to medical school, you learn a reflex. You learn diagnosis, treatment, diagnosis, treatment. I mean, there are thousands, tens of thousands, of things to memorize in medical school. How do you ever jam all of that stuff into your mind? You’ve got to pair them. You’ve got to pair a diagnosis and a treatment. And you come out of medical school with this reflex. You see something, and automatically, your mind pops up the matching treatment for that – the finding on the X-ray or the symptom.

That is part of the culture of medicine, but now people are saying, “Wait a minute, maybe we’ve gone too far.” If you look at some of the giant recommendations of the field of medicine for the entire population of the world, the first time ever in the history of mankind, the medical
community has told the public every healthy person needs to take a pill. That pill was called aspirin. We told everybody for decades that everybody should be on an aspirin once a day.

And a lot of people were saying, “Wait a minute, do I really need to be taking a pill every day?” There were studies, and they looked at certain outcomes. But you know, just in the last eight months, another giant study has come out, showing that the internal bleeding consequence balances out the benefits to your heart.

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And we’re now pulling back that recommendation. If you have a healthy heart, if you don’t have a history of heart problems, we’re now pulling that recommendation back.

Same thing with PSA testing. You’re seeing the medical community say, “Wait a minute, we don’t need to do a PSA test for prostate cancer on every older man in the world.” We’re seeing the recommendations on breast cancer screening with mammography in that middle-aged group being pulled back.

We’re seeing a lot of research coming out now that’s saying some of these giant recommendations to do more stuff probably were not based on sound science. When we look at the full gamut of outcomes, we may be creating too many false-positives and hurting as many people as we’re helping.

So, it’s an exciting time in medicine. I am very optimistic about the direction of medicine right now. Doctors are speaking up about this problem. And you know, quite honestly, overtreatment is something that we are passionate about. It bothers us. We just have to really have a good forum to speak up. So, I think now we’re seeing doctors speak up about this issue.

DM: I definitely like to discuss that with you further and comment also on the fact that you mentioned there are these protocols that have been established. I think philosophically that’s where much of the attention’s going to need to be focused, because we have this continually evolving improvement in artificial intelligence so much so that in the next 20 to 30 years, our smartphone will be smarter than any person on the planet. And they will be able to essentially interview a patient like a physician and then spit out an entire battery of recommendations.

That’s going to be pretty programmed in, of course. They may have enough intelligence to just scour the literature or update them. I don’t know. Who knows what’s going to happen in 30 years? But nevertheless, there’s this challenge that you alluded to earlier that even the Institute of Medicine acknowledged: 30 percent of the care being rendered is unnecessary.

So, you were trained in one the most prestigious public health institutions in the country – or maybe the most prestigious. And you’re actually filming in Johns Hopkins now. I’m wondering if you have a quick comment on – because you’re part of that network and community… Do you notice an increase in the appreciation of this fact and of some efforts being addressed to counter that? Because, I mean, you’re basically an insider.

MM: Well, I’ll tell you. There are a lot of us that are busy practicing doctors that are saying, “Look, some of the stuff we were taught in medicine was completely wrong.” I was taught, for example, that everybody has one million nephrons (or the sort of cellular unit) in a kidney. We
now know that’s not true. We now know that it ranges from 200,000 to two million. And if you have a lot, you may have more of a reserve. If you have few, you may be more frail in your ability to withstand an insult to your kidney.

You know, we were taught fat was bad for you. We were taught, “Don’t eat fat. Fat is bad. Low-fat diets are important for everybody.” That was probably wrong advice that the medical community gave to the general public.

What’s far more important than avoiding fat was limiting the amount of sugar, a highly addictive substance, which results in heart disease and has many detrimental effects, mainly the hormonal effect of changing the fat storage balance. And of course, what we did as a medical community is we demonized fat. We created in a few decades where a generation became addicted to sugar. And the sugar changed fat metabolism. We’ve seen the largest growth in obesity in the history of the country.

You know, we are now the most disabled country in the world. If you look at disability as a proportion of the number of people per capita, we have the most disabled part of our population of any developed country in the world. And that’s because we’ve got obesity leading to chronic diseases. Many of these things are lifestyle problems.

We’re now recognizing that some of the emphasis in the direction that we had in medical school was just not based on the solid evidence that we’re now seeing. And you know, in terms of what the medical community is saying about this problem, the medical community is divided. We have got now a group that’s leading the charge to say, “We are doing too much as a group of doctors in the United States. There’s too much medical care. It’s in part driven by the culture of medicine. It’s in part driven by the perverse incentives that are out there.”

But we’ve got now the American Board of Internal Medicine Foundation. We’re talking one of the largest physician organizations in the country. Now they started a campaign that identified the most commonly overdone tests and studies in the United States.

They’ve assigned every specialty a task of identifying five things that are overdone in that specialty. And they’ve got a list. It’s on their website. The campaign is called “Choose Wisely.” They’re putting this list out there to the public, saying, “If your doctor recommends one of these five things that we tend to overdo, then choose wisely. Think twice. Get a second opinion.”

So, Joe, I think quite honestly, this is a very exciting time in healthcare. We are seeing an active conversation about a problem, which we haven’t been talking about for a long time. We need that conversation badly. I mean, healthcare costs are burdening every family and business in America. When you talk to anybody out there, they’ll tell you they’re paying more of their deductible this year and their premium is going up, and they don’t even know what they’re getting in return. I mean, people are getting crushed out there.

The national debt, the cost of businesses, and the cost of hiring employees because of health insurance. We’re almost going to be paying for our own healthcare on our own. It’s just going to cover the very high and catastrophic costs.

So, people are getting fed up with the system. When they see that the Institute of Medicine is calling out 30 percent of what healthcare does as unnecessary and even fraudulent at times,
people are getting angry, and they’re speaking up. We’re seeing this conversation for the first time in American medicine among doctors. I think that’s a very healthy conversation to have.

DM: It seems like the process is going to get worse with the passage of the Affordable Care Act and the continuation with Obama’s re-election, because it tends to continue the same process. I thoroughly agree that people should be covered, but they should be covered with appropriate care, not care that’s going to continue the same problems that you address in your book.

And speaking of your book, it seems like one of the strong motivations to write it was, as you mentioned earlier when you introduced your first comments, there’s this code of silence among physicians that really seems to be prevalent and really, for the most part, the public isn’t aware of. I’m wondering if you could comment on that as to what are some of the reasons why this code of silence exists, and why it isn’t more widely exposed.

MM: You know, look at a pre-med student in college applying for medical school. Look at the kids applying for the Johns Hopkins Medical School. We could walk over to the admissions office and sit in the lobby, where the applicants are waiting for their interviews. And what you’ll learn is that there is a tremendous amount of creative talent in that group.

I mean, these are amazing folks. They’re smart. They want to do great things. They want to contribute to humanity. Most of them want to do medical missions to some degree. I’d say about 95 percent of our applicants want to do foreign medical charitable works to some degree in their practice in their career.

But then you look at the graduates of our system. You look at people when they come out of their medical training. They look very different. They’re sometimes burned out.

We’ve got a study from the Mayo Clinic that says that 46 percent of doctors in the U.S. are burned out. That’s the Mayo Clinic; that’s not our opinion. We’ve got a very few people doing charitable work. We’ve got people delivering the same message. And I think when there’s that degree of burnout or exhaustion, when the culture has sort of transformed highly creative people that much, you’re going to have problems when we are just not simply taught to question a lot of what we do.

When I was in medical school, I remember that we witnessed a patient undergo an operation that the patient should not have had. It was well agreed upon by the team – and we’ve been talking around the locker room – that this patient should have never had surgery. When one of the doctors that I looked up to had found out that this patient underwent an unnecessary operation, I noticed his reaction.

What I noticed is that he looked… He had an expression of disappointment, and he just looked down. I think that has been the reaction. By and large, when we see something that doesn’t look right in healthcare, we internalize it. We don’t have these forums to talk honestly about different ways of doing things, best practices, or using solid evidence.

I think if you look at the way that we sort of monitor our own performance in healthcare, we use something called internal peer review. Many doctors will tell you internal peer review is littered
with problems. I mean for one, there’s the local politics of your own department or hospital, and two, you don’t get the expertise from sort of a national benchmark. There’s no external peer review. We’ve got to have some external peer review. I think we can’t rely on the medical profession to really police itself for that high degree of reliability that we need in society.

What we’ve got to do is educate the everyday patient to empower themselves, to understand what they’re having done, and to learn to ask the right questions. We’ve put together a list of sort of important questions a patient should ask, and we’ve put it on the book website, UnaccountableBook.com. Things like, “Do I really need to have this done? What if I don’t take this medication? And then whatever that consequence could be, what are the odds that that could happen? And if it does happen, can we treat it once that happens?”

I mean, I remember consenting people for surgery as a resident. I was way over my head. They would ask me, “What happens if I don’t have an operation or take a medicine?” And I just give them a standard answer sometimes. “You could die. Something could go wrong.”

And yet, I was rushing. You’re working sometimes for 40 straight hours. You’re working 120 hours a week. As a resident, you’ve got a mission. You get certain things done to get through this little list of things you need to do during the day.

And sure enough, the research – now that we have it – shows that most patients are undertold the risks, and they’re overstated the benefits to medical procedures, tests, and medications.

There’s a lot that we can learn from ourselves. We’re starting to talk about this. Thank, God, there’s people out there like yourself that have been talking about this for years. It’s a healthy conversation.

And you know, I just want to emphasize, doctors are good people. They intend well. They’re working [inaudible 22:04-10], and a lot of them are getting crushed right now. Practice costs and the premiums are going up. Overheads are going up. Medicare payments are going down. I mean, doctors are getting crushed right now. It’s no wonder we’re seeing a 46 percent burnout rate in this Mayo Clinic study.

DM: I couldn’t agree more that the physicians… But really, the crux of the problem is not with the physicians. There are clearly some physicians that shouldn’t be practicing, but that’s true with any profession.

The other component though is that this whole system is designed to transform people in medical school, as you mentioned. From the students who are answering to the ones who graduate, there’s a significant difference. It puts them on these pressures. They graduate typically with debts of a quarter million dollars or more, which is common. And then they have to address that, the high cost of housing, and paying back all those loans. So, it motivates them in directions that they wouldn’t have been motivated before they started school.

I thank you for your recommendations. The only concern I have is that when a patient seeks to implement and ask the physician questions, they’re on all these [inaudible 24:13] and they’re not going to be able to carefully explain the alternatives and really address the lifestyle issue. It’s
important for people to understand that that’s what they’re working against. They have this high pressure.

Frequently, the simplest and most efficient way from their perspective is that prescription pad. That you know, they’ve done their job, and you’re out the door. Or in your case, since you’re a surgeon, it’s a surgical procedure.

You know, I’d like to keep the rest of the conversation on the positive of things, but that can’t be, because as I said, you’re an insider. You’ve seen the system from the inside. You know some of the dangers that that system holds for people who aren’t aware of those. So, I’m wondering if you can discuss some of the most common mistakes that you’ve seen, from your perspective, and recommendations that people can implement to protect against those mistakes.

MM: Perhaps another mistake is the issue of overtreatment, if we look at the statistics from the Institute of Medicine. Number two is under-referral. You know, a lot of medicine is sort of a salaried group model. That is, the doctors are going to do whatever is in your best interest. They don’t really have financial incentives. But then there’s a lot of medicine where there are strong financial incentives.

Think of it as a referral business just like real estate or law. If you’re talking to a real estate agent who really doesn’t know much about the area you want to live in, do you want somebody who’s just going to kind of wing it? Or do you want someone who’s going to say, “You know, let me refer you to somebody who really knows this area well. They know every corner and block.”

Medicine is the same way. We’ve got a referral business with strong financial incentives. There are probably not enough referrals to specialists as there should be.

I think sometimes you need to take things in your own hand and just ask for one. Or say, you know, “Would it help if I spoke with someone who specializes in this?” Or go to their websites and find the experts. There are some very good websites out there now for patients, [like] ConsumerReportHealth.org. Medicare is not putting a lot of hospital performance up on the web in their website Hospital Compare. It’s HospitalCompare.hhs.gov. So, there are some good resources out there now.

You know, if anything else, I like patient satisfaction scores. When I go to ZocDoc.com, and I see that there are 2,000 reviews of a physician and on average the physician gets 4.5 out of 5, I have a good feeling that this is a doc who listens and will spend whatever time is needed until the questions are answered.

I made a mistake once on one of my patients. I ordered the wrong test. I ordered an X-ray on one patient, there was a bit of confusion, and it ended up being done on another patient. As soon as I learned about this, Joe, I ran to the patient’s bedside, and I said, “Look, I’m so sorry. You had an X-ray. You didn’t need that X-ray. It was a mistake. I’m sorry.” And I went to the other patient, and I said, “You didn’t get your X-ray, because there was a mix-up. We’re going to make sure you get it done today.”

To my shock, I thought these patients were going to be ticked off at me. Instead, they both looked at me and said, “You know, doctor, thank you for being honest and for coming here and for telling me that.”
I think people are hungry for simple honesty in medicine. They want to be treated with dignity and with respect. They’re even okay with the medical mistake, as long as somebody can be very honest with them and explain what happened.

Now, there’s a lot that we can do to engineer mistakes out of a system. And I think there’s a lot of exciting work in that area right now.

**DM:** Yeah, I couldn’t agree more with the transparency, the relationship, and the communication skills you have with the person. I’ve studied the malpractice issue. I think most physicians at some point in their career, even the best ones, are sued for a variety of reasons. But the factors that seem to lead to the lawsuits are the lack of communication with the patient. I’ve noticed that that seems to be a really powerful precipitant.

I just like to comment on your encouragement to get a referral. I think that’s a wise thing certainly. But maybe it might even be helpful to take a step back and see if you even need that process to begin with, because that referral may just take you further down the road. You got maybe a super specialist in that specific area, and he can answer every question, but there may be another option that that system wasn’t aware about. So, you may have to go to your local community.

And I like, you know... As a general way, it’s not been socialized yet, and there’s not really a good system on the Internet I’m aware of. But the best traditional approach is the health food store. I mean, go to several of them in your local community. These are people who have network to the local healthcare resources. And they know who’s good and who’s not, because the bad one comes through word of mouth. That’s sort of like your local Facebook equivalent. You could figure that out pretty rapidly. It doesn’t cost anything. And then you can go into a different direction and explore it from that perspective.

But clearly, there are times when surgeons are needed – there’s no question. Thank God, we have them. They save lives every day. I’m wondering if you can provide a checklist (I think you developed one for your book). If you could review that checklist with us, so that when those times when surgery is appropriate and indicated, we could follow the checklist and minimize our chances of adverse risks or consequences.

**MM:** If you’re looking for a place to deliver a baby, if you’re looking for a place to be treated for a stroke, or if you think you might have Lyme disease and you want to be evaluated, there are all kinds of different important questions to ask.

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Honestly, sometimes, I ask an emergency-room nurse. I find that a nurse in the emergency room sometimes knows more and has more local wisdom about who’s good. They know the doctors that come right away when their patients are sick, and they know who answers to the pages.

But you know, for a lot of folks out there, if you don’t know of a nurse, secretary, doctor, or technician that works for a hospital that can give you this scoop on who’s really good, ask some of these important questions.
For surgery, ask, “Do I really need this done? When am I going to be back to feeling good?” A lot of patients are just told when they’re going to be discharged from the hospital, but when you’re back to feeling strong again is a totally different question. “What if I don’t have this procedure done? Can I wait a year and see if this gets better? What if I do wait a year and something develops in the interim? How do we handle that at that point?” So, these are some important questions.

I often tell my patients, “Get a second opinion.” It may give you a peace of mind. You should feel free to do so. And you know, I find that when I encourage patients or at least offer they get a second opinion, they seem to trust me more. They tend to feel that I got nothing to worry about in giving bad advice that someone else there is going to supercede. I think it’s a good thing for patients to ask those questions. “How many do they do? Is this the hospital in the area that does the most of these procedures?”

I’m not all about rating doctors. I think if we start taking all the stats on all individual doctors and put them out there, what we’re going to see is that the young doctors have the worst stats, because they’re just getting going. It may not reflect that they’re worst; it’s just going to reflect that they had one complication out of 10, as opposed to 10 out of a 100 for someone more experienced.

You can never get good statistical validity on individual doctors in any way that’s feasible, but we can have more accountability at the hospital level. When there are bad outlier doctors at a hospital, the hospital can deal with that, because they are accountable for their hospital’s performance.

There’s a lot of good stuff out there now. When I talk to patients and say, “Why did you choose to come to this hospital?” I hear answers like, “The parking was good here.” I mean, we can do better than that as a profession. Our performance is now being tracked and measured. That information, I think, should be available to the public at the hospital level.

There’s a revolution in healthcare right now. It’s an exciting time. Doctors and hospitals are saying, “Look, we believe that our performance should be in the public domain.” People should be able to look up our infection rate, our re-admission rate, or what we call bounce-back rate after someone’s discharged. They should be able to look up our patient satisfaction scores. There’s a movement – a revolution – that we described in the book Unaccountable, which is starting to provide these metrics on certain websites, so that patients can navigate the healthcare system.

There’s a hundred or over a hundred of national registries in healthcare. When I do an islet pancreas transplant for a condition called chronic pancreatitis, that information goes to a national database. Now, that national database is funded by taxpayer dollars, but the taxpayers have no access to it. Many of these national registries are confidential. I think we, as a society, are asking the question, “Does the public have a right to know about the quality of their hospitals?” And I believe they do.
DM: Great. I just want to follow up on one of the points you made with respect to finding out if you need a procedure in the first place. That’s really important, because the hospitals can be very dangerous places. Mistakes are routinely made – not intentionally, of course. But you know, it’s a mistake, and people die as a result of that. So, I’m wondering if you could comment on some of the safeguards that people can implement once they are hospitalized.

We had another doctor, Dr. Andrew Saul, who actually wrote a book on that. I believe he recommended to have a friend or a relative stay with you. Because frequently, you’re going to be relatively debilitated, especially post-op when you’re under the influence of anesthesia, and you won’t have the opportunity to see the types of processes that are going on. So, from your perspective, what have you found to be some of the most helpful strategies?

MM: I have a [inaudible 35:03] hospital. And of course, I wanted to be involved in the care. I said, “Can I spend the night in the room?” And he looked at me like, “What kind of crazy request is that?” They kind of… I would say, they reluctantly accommodated me. I asked for a copy of the medical records, and they kind of ping-ponged me around the different parts of the hospital.

This wasn’t the hospital in which I work now. But you know, I was just… I felt like I was a… They made me feel like this was deviant behavior to ask to spend the night and to get a copy of the records.

These are important things that patients and their family members need to do. Hospitals are realizing that now. Our hospital here at Johns Hopkins now invites a family member to spend the night with the patient. And not only do we accommodate the family member, we encourage it. We’ve got a comfortable place for the family member to stay in the room.

It’s important to be there. For every medication given to your loved one in the hospital, ask, “What is this medication? What is it for? What’s the dose?” Take notes. Now, you don’t need to be suspicious of everything. It creates animosity, and I think sometimes patients get worse care. But there is a way to sort of politely be a part of the team. Ask questions.

You know, when I’ve got a friend who’s got a loved one in the hospital, I tell them, “You know, bake a cake and bring it in for the nurses.” Nurses are oftentimes getting crushed. They’re under intense pressure to see more patients and work tough hours. They really like it when they can develop a nice relationship with a patient and their family members. That relationship goes a long way.

And sure enough, I’ve heard stories where people have said, “The nurse came in to give a high dose of heparin. And thank God, I asked him/her, and they actually made the correction.” So, there have been some good [inaudible 37:01] from loved ones in the hospital.

DM: Absolutely. When they realize they’re going to be questioned, they’re going to do an extra step of due diligence to make sure they’re doing [it right]. That’s a powerful step and recommendation I think people could implement.

Now, specially, there’s a population that goes to the hospital that really can’t fend for themselves at all even in optimal health, and this is the pediatric population. They don’t know. They’re kids. They have no idea or concept of what to be aware of, especially with medication areas. Can you
comment on that group of people? And are there any extra steps they can implement? Or additional steps?

**MM:** Sometimes, we rely on a competent talking patient to sort of verify things before we go in the operating room. But if we got somebody who’s not mentally coherent because they’re elderly or a kid and there’s no family member around, these are sort of danger zones. These are high-risk areas for medical mistakes.

It’s important to ask what procedure’s being done or why is the procedure being done. “Can I talk to the doctor?” You have a right to know about what’s being done to you or your loved one in the hospital. When you’ve got a kid in the hospital, I think it’s particularly important to ask the questions. And you know, the pediatric nurses in the hospital, they are very good. And they’re very good about relaying your questions right to the medical team. I think we’re seeing more of that.

Of course, you may know, Joe, we had a tragic complication involving a young girl here at Johns Hopkins years ago. A young girl who died from a medical mistake. It was preventable. The hospital was very open and honest about the mistake, and has even partnered with the family to do work in patient safety. I think we’re learning more now about how to design safe hospital systems. I think we’re seeing safety improve in the hospitals that are making it a priority.

**DM:** Well, in that point, it really alludes to the issue of transparency, which is a big focus of your book and your belief system. I’m wondering if you could comment on that and other steps that can be taken to improve transparency not only from an organization-hospital perspective, but also from an individual position perspective.

**MM:** When we try to measure an individual doctor’s performance, we don’t have good ways to measure an individual doctor. In fact, making the performance of an individual doctor transparent is simply going to punish the doctors that accept the high-risk cases and reward those that avoid them. We create perverse incentives to discriminating.

But now the metrics to measure healthcare quality are far more mature. We have good ways to measure a hospital’s performance – the infection rates, re-admission rates, patient satisfaction scores, and the surgical complication rates. Wouldn’t you like to know how many of a certain procedure the hospital does in a year?

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If you think you have Lyme disease, do you want to go to a hospital that has seen one case in the last year? Or a hospital that may have a [inaudible 40:10-15]? A center with one doctor who specializes in stroke or a hospital with a department and has seen hundreds of cases in the preceding years?

This is basic information. You know it’s out there. It’s being collected. The ways to measure hospital performance are now maturing to the point where they need to be available to the public. And we’re seeing that transparency revolution take place.
I believe it’s going to reshape our entire healthcare landscape. Instead of choosing a hospital based on a billboard advertisement or valet parking at a hospital, you should be able to look up a hospital’s performance – their quality, their volumes, and their satisfaction [rate].

You know, 60 percent of New Yorkers will look up a restaurant’s ratings before choosing a restaurant. Yet people are walking into the hospitals blind to the hospital’s performance.

That is changing. We’ve got organizations like Consumer Reports Health and Medicare putting information out there in an easy-to-understand fashion, and it’s increasing accountability at the hospital level.

We expect the transparency of the White House and Wall Street, yet medicine seems to be on an island. We have different standards, different ethics, and different expectations. We almost sometimes get so flustered with healthcare. We don’t even think of it in terms of the same metrics we hold any other industry.

So, we’re seeing an exciting revolution now in healthcare. It’s a transparency revolution, and it’s really the basis for writing this book, Unaccountable.

DM: Terrific. Now, part of the very nature of being human is that we make mistakes. No one is perfect. Mistakes will be made. And with the implementation and the movement toward more transparency, these mistakes will be known. So, what recommendations do you have for patients who find out that they’ve been a victim of a mistake? Are there any things that they can do? What approach would you encourage them to follow?

MM: There’s a Facebook page, Patient Harm. There are communities. There’s Citizens for Patient Safety. But you know, if you’ve been harmed from a preventable medical mistake… Now, I’m not talking about a routine complication that everyone knew was a possibility. I’m talking about a preventable medical mistake. I’m talking about what the New England Journal of Medicine says happens up to one in four times when somebody is in the hospital.

Talk to the doctor. Ask to talk to the doctor about that mistake. If you’re not satisfied, write a letter or call the patient relations department. Every hospital is mandated to have one of these. They are set up to sort of answer these concerns. If you’re not satisfied with that, write a letter to the hospital’s lawyer, the general council. And you will see attention to the issue, because you’ve gone through the right channels.

We don’t want to encourage millions of lawsuits out there. But you know, when people voice what happened, what went wrong, and the nature of the preventable mistake, hospitals can learn from their mistakes. Sometimes they’re taking a lot of attention now to prevent mistakes from happening again. You should let that mistake be known.

I hear all the time… I travel around the country almost every other week, and I hear stories of, “You know, my father died of a medical mistake. It was totally preventable. It was tragic. He didn’t even need the procedure for which there was a complication. And we decided to just not do anything.”

Well, I think it’s good to at least have that dialogue with the doctor, so the doctor can pass it on to the hospital staff. Sometimes, I use that information to take it back to the hospital and say,
“Hey, look, we messed up here. How can we do this better? How can we prevent this from happening a second time?”

**DM:** Yeah. Those are all good recommendations. I would also add that if for whatever reason the physician isn’t as committed to transparency as you obviously are... Especially in many surgeons, there’s a tendency toward being arrogant. If he refuses to discuss it, then it seems to me one of the most effective strategies is to report them to the medical licensing board. That’s, in many cases, even more potent than a lawsuit. It’s not going to, you know...

With respect to changing behavior, because they’re following the [inaudible 44:58]. If they lose their license or their license is medically reprimanded, that is a serious barrier for them to actually continue their profession. So, that could be a powerful motivation.

Now, I’m wondering, from a hospital perspective, if you can comment on the factors that have contributed to this increase in mistakes. Because if we’re aware of these factors, maybe there are ways so that we can sort of prevent them.

**MM:** Medical knowledge has exploded. And yet at the same time, what has not kept up with that explosion is the coordination of medical services. We’ve got doctors that specialize in things I’ve never even heard of. I met a doctor in ophthalmology. I figured an ophthalmologist is a specialist in the eye. Well, I learned from this doctor that he’s a specialist in something called the choroid, something I didn’t even know existed. It’s a part of the eye. I didn’t even remember it was there. That’s how specialized people are.

We’ve got this pitfall behavior that happens in every industry, where we refer to it as “when you’re a hammer, everything is a nail.” It’s the sense of not having a broader context of all the issues in the patient when you’re looking at your specific area of specialty. As a pancreas surgeon myself, someone who does general and GI surgery, we can fall into that pitfall.

So, the coordination of medicine has not kept up with the growth of knowledge. When you’ve got a patient that falls through the cracks, you’ve got patients that are basically told, “We don’t know what to do; there’s nothing that can be done.” When in fact, there are just specialists out there that sometimes we’ve never heard about.

We’ve developed a checklist for surgeons to use before they do an operation. And actually, it’s for any doctor that is going to do a procedure in the hospital. My research partner, Peter Pronovost, created this checklist in the ICU for patients that are in the intensive care unit. Then he came up to me and said, “You know, Marty, we should come up with one per surgery for new surgeons to use when they do a procedure in the operating room.” And we developed a checklist. We published several articles about the checklist.

The World Health Organization took an interest in the checklist and developed the official World Health Organization checklist, which was based in part on some of the principles in our checklist. Now this checklist is almost, to me, hanging on the wall of every hospital in the world. It has a broader message, and that is standardization.

Why is it that some surgeons give the proper antibiotics before surgery, and other surgeons don’t? Well, they’re not diabolical. They’re just busy. We have a lot in our minds before we go into surgery. Sometimes it’s not an individual surgeon’s... It’s not in their ability to give the
antibiotic. They have to call for it from pharmacy, it gets handed to the nurses that hand it off to the anesthesia provider that gets them delivered. It’s a complicated place. Surgery is a complicated place.

So, these checklists have improved safety by standardizing some best practices in healthcare.

**DM:** Is there a place where a patient can download these checklists, find out what they are, and give them to their surgeon in case, they’re one of the few that don’t have them?

**MM:** It’s WHO Checklist for Safe Surgery, which is part of the campaign “Safe Surgery Saves Lives” that we were a part of for the World Health Organization.

**DM:** Well, terrific. Was that part of your public health initiative to establish that?

**MM:** Absolutely, yeah. This was a big project. Atul Gawande was the [head of the] committee. I did several things, including to find ways to measure quality of healthcare that are standardized for surgery around the world.

For the first time, we are seeing a real international dialogue about quality, safety, medical mistakes, and how we, as doctors, could be more transparent from the bedside to the hospital performance level.

**DM:** Well, that’s terrific. You’ve really compiled a wealth of resources. I suspect most of them are in your book *Unaccountable*, which is available online on Amazon and is easy to get. I’m wondering if there are any take-home messages or points you’d like to emphasize as we’re getting ready to close.

**MM:** It’s going to be the patients that will really drive quality performance in healthcare. I think there are some good ways out there as of this year – and they’re getting better with every subsequent year – to measure a hospital’s performance. If you’re interested in how something performs before you use the services, it would make sense to be a part of this transparency revolution.

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That was really the impetus for this book, *Unaccountable*. So, thanks so much for your interest and for bringing some attention to this movement within healthcare.

**DM:** Is there a website for your book, too?

**MM:** It’s UnaccountableBook.com.

**DM:** UnaccountableBook (all one word, no spaces).com?

**MM:** That’s right.

**DM:** All right. Well, thank you for your work and efforts in helping make this world a better and safer place and more transparent. I think we could all use a big dose of that. So, I really appreciate your time and energy today.