Dr. Atul Gawande *No Turning Back*

CHRIS: Hey everyone. Thanks for joining us for this week's discussion. Stan and I sit down with Dr. Atul Gawande, just a truly exceptional individual and thoughtful leader in the healthcare space.

Atul is a practicing physician, a surgeon in Boston, but has had a wide-ranging career outside of the operating room. He's the author of four books. He was on President Biden's COVID transition advisory team, going back to his early days undergrad at Stanford, Stanford Rhodes scholar, got his medical degree at Harvard, so truly impressive intellect.

But then went on to write deeply about the importance of leadership, different types of thinking, his own personal lessons as a surgeon and a leader in the, the healthcare space which we talk about at length during the discussion. I think you'll find a, a leader here from a space that is known more for practice than its leadership the, the healthcare sector, but that's something that's changing. As healthcare becomes increasing more, increasingly more complex accelerated by the, the the pandemic of the last year. Gawande has been at the center of many of those discussions, not just the past 12 to 18 months, but throughout a long and very impressive career.

So, we hope you enjoy this discussion as much as we did. Thanks again for tuning into no turning back.

STAN: Atul, thanks for joining us today. I really appreciate it. And I've been excited to talk to you after our earlier conversation. And I want to start with the idea of a person's relationship to their physician. Like a lot of people who, whose work or lifestyle had a certain wear and tear on their body.

I've had 10 orthopedic surgeries. And in December of 2019, I had to have most of my spine fused. And so, I went to a series of doctors and I ended up with a very accomplished physician in New York city to do the procedure. But I guess on questioning, I asked myself, am I hiring a really good mechanic who knows how to do bolts and things?

Or am I hiring a leader? And what should I been thinking about? What should I have been looking for?

DR. ATUL: Well, there's no question. You're hiring more than a mechanic. And there's so many levels of dimension here to what that leader you're looking for is and some of it's in their control and some of it's not.

So, you're also choosing a system at the same time. So, on the leadership level, one of the things you're choosing is someone who I would call a counselor. They would be someone who is able to help you elicit and articulate your goals. What are you aiming to accomplish? A counselor isn't like a retail salesperson who tells you, you know, do you want the red shoes or the blue shoes?

Here are the pros and cons, risks and benefits. What do you want? This goes farther because you're wanting someone who can match what the options are to your goals. And we don't do-- most of us in healthcare-- don't do a good job of eliciting your goals. What do you, what do you expect out of the orthopedic surgery? You expect to be playing tennis again?

Are you expecting to just be out of pain? Are you, you know... and then match the goals, the options to those goals? On the most basic level, that is critical. Do you feel you have somebody who can do that? Second, is then if you're able to work with someone you can make good decisions with. And if you don't feel you can make those good decisions, walk. You have to have someone you can work with.

But the second part is then can they deliver on the, on, on the promised goal? And that is a you know, we've learned a lot about how experience matters and volume of experience, et cetera. But one of the things people know less about is how much you can take someone who's experienced and put them, you know, we, we see differences in surgeon's performance now, a lot of us practice in more than one setting. You know, you might be in a hospital in an ambulatory center, in two hospitals, or three hospitals, and your results are shaped by the place that you are in. The system around you matters because it is not just an individual. This is a team sport.

Virtually all, not not everything in medicine's this way, but most of surgery is about whether they are part of a team in which sometimes they're leading at moments and other times they are the follower in moments. Who has a sound system around them? That has the organizational capability to generate constantly improving results are open and transparent with themselves and have built a culture of of enabling them. That's all invisible to you. You know, you're like, you're like the passenger on the, on the plane, you know, how do I know they're using the right checklist?

And that they're, they're a good team up there in the cockpit. You can't know. And that is why it's up to us, and also those who pay us, and those who oversee how we're trained, and how we're organized and et cetera to be, and, and the public in general, to be part of the solution in making a better, a better system.

So that was probably more than you were looking for.

STAN: Where were you when I was making the decision?

CHRIS: Well Stan's still walking. So, some, something's working the on that last point, Atul that the leadership idea in healthcare and even all the down to the small team level inside of a specific hospital, I've always seen parallels between growing up in the SEAL teams and the medical community.

It, through that lens, I grew up in a, in a medical family, my dad, both grandfathers, sister, brother-in-law all, all physicians. I got a C minus in freshman biology and transitioned over to philosophy as a major, which was a good choice on my dad's advice. But the going into the SEAL teams, one, most people don't join the SEAL teams because they want to be led.

They want to be a SEAL. They want to be that operator who goes in and, and, and is in charge of the mission. They want to be the first person through the door going into harm's way, whatever image they have in their head. It's not taking orders. Right? That's an outcome that you start to learn the importance of when you understand how teams work.

Right. And I think there's a similar dynamic in healthcare, right? You don't go to medical school because you want to work for a hospital administrator. You want to be a physician, doing what physicians do. But you've clearly evolved in your career into understanding the importance of both of those. Can you talk a bit about if I, if I'm accurate, if I'm right there, can you talk about that moment or series of lessons where you realize the importance of both aspects?

DR. ATUL: Yeah. You know, in my training, I was constantly asking the question, "how do I, how do I get good at, at, at this?" Professionally being a surgeon and seeing how much of it was out of my control. You know, dependent on the entire team functioning well and, and really finding, we knew nothing. We, we, we train our young surgeons all very little in leadership and what that really means, and we're trying to, and the place I saw it was I got to be part of a study, looking at the results of surgical care across hospitals in two different states.

So, 28 hospitals and tens of thousands of patients and the and found that first of all, surgeons do well, 97% of the time, there is no major disaster. You know, we didn't, that's not necessarily success, but at least, you know, no major complication or death. However, 3% of the time with hospital surgery, there is a major disability or death that is an outcome of, of what happens.

And there was enormous variation. There is a big gap between the performance in the bottom quarter to the top quarter. I'm talking, you know, fivefold, sometimes 10-fold differences in complications and deaths. And so, then I got really interested. What are the people doing at the top that I can bring to me and by extension to others?

And and what we, what, what we gradually found the evidence of was just, they were better teams. And then the question is, how do you replicate it? And actually, got a Boeing safety engineer to work with me on a world health organization project. I got pulled in, as I started writing about these, this question of performance and the world health organization saw that there was an explosion in surgery around the world, and as a result in the death and disability and, and you know, the, the quality wasn't there and, and how do you drive that?

And so, we ended up. Designing a checklist, a team checklist that was really a communications tool. How do we get on the same page in a, in two minutes? Like my whole goal was three checkpoints before patient goes to sleep before the incisions made for the patient, leaves the room, and I want it to be under 60 seconds at every checkpoint.

We average about two minutes for total time to do the checks. And it really is just communication. What is the goal? What's one of the specific things we got to know about this person. And does everybody have a conversation about all of their 19 critical elements that we all need to discuss? And did everybody get a voice in speaking up?

And one of the things that's on the list is do I know everybody's name in the room and what their role is, and by letting everybody go around and say your name and, and who you are. Cause we have a new team every day. You have activated them to speak up. And to be part of the team and and, and the results of deploying this was shocking much greater reduction in complications and deaths than I ever expected.

It was more than a third this you know, we haven't had this, we haven't had that kind of massive regardless of the operation. A greater than one third reduction in deaths and complications as big as anesthesia, as big as the discovery of antisepsis. And and one of the things about, about it that I really came to recognize later was the culture of the operating room had been one where our norm was the autonomy of the surgeon, what the surgeon says goes, and that operating room was built to serve that surgeon.

And we were changing the culture to flatten the hierarchy and to say the autonomy that surgeon is going to take second place to humility, recognizing that anything can go wrong, no matter how experienced anybody is in the room. He disciplines doing certain things the same way. Every time we'll get you to a better result and, and save you from some of those errors and teamwork.

The belief that anybody in the room can make this operation better. It doesn't matter who they are or how inexperienced, just by asking even, you know, raising your own doubts and speaking up and that and the places where people adopted the checklist with that spirit in mind and actually elevated their teamwork.

Those got the, got the reductions in deaths, the ones that just turned it into a tick box exercise. No reductions in deaths.

CHRIS: Hmm. I read checklist manifesto when I was still in the service on a deployment Afghanistan, actually. And I think a great book is one that isn't in that space is one that you read it and you sort of say, of course, like, why haven't we been talking about this forever?

So, I be curious your, your thoughts there, that, that concept as it applies to medicine and, and beyond like, why. Why did it take so long for that, that type of thinking to bubble up? Or was there a school of thought then you just were able to pull it together? Because I, I love that you have you're across sort of a sector thinker.

After seeing that work, I was, I tried a few times when I was in SEAL teams to get some. A group of young officers to go and spend time in different environments to watch like if you've ever been an ops center in the special operations world, I wanted to take those same officers. Yeah. But I would love to see, it would look, it would look familiar.

Right? It's it's it's chaos. So, some things have to be structured. Some things have to be fluid. I wanted to go watch the kitchen in a high-end restaurant on a busy night, but I could never convince the senior leaders that it wasn't a total boondoggle. Like, look, they, they are doing something with precision in chaos.

Like there have to be lessons we can learn from those different environments. So how, how did you how did that, how was that message of cross-functional thinking received when you started to push?

DR. ATUL: Well, first to explain where, you know, you started with, how, how, how has healthcare evolved to be in that place?

There was a time when. When knowledge doesn't exist when, when you don't have clarity about some can do it better than others then. And what drives that? Then it's a craft and a lot of surgery was craft for much of this existence. It was. You know, it was not getting to the point that you could routinize and standardize.

And you knew what you were developing as soon, as soon as we added two things, one was the complexity of. You know, my mother had a knee operation and and it went well. So, I was sitting in, in with her for three days in the hospital. And I just counted all the badges that came in the room and either made a decision about her care in the next few hours or delivered on it.

And I had 63 badges. 63 different people taking care of them and that no longer, you know, each person can't be a craftsperson. They can't, they can't be like, I've got a special design for what I'm going to do. You know? And, and sometimes it's worked that way. You'd have a physical therapist who come in in the morning and they'd be like, what are you doing in bed?

You should be out of bed. And then literally in the afternoon, you'd have a physical therapist saying, what are you doing out of bed? You should be in bed like enough with the craft we have to have, you got to get our crap together here. And. And so complexity and then the discovery of, you know, we, we gathered data and found there is ways to have better performance in, in certain routinized aspects of things.

Well, getting to that place. Meant it was all about how I brought it to people in my profession. There was definitely, I mean, I've been thrown out of operating rooms all over the world and, you know, one survey I did with surgeons after three months of adopting the checklist you know, no one goes in liking it.

And at the end about 75% would say, you know what? We, I, this, there was, this helped me catch an error. It didn't take as long as I thought. In fact, you know, it may have saved time, et cetera. But about 25% were consistently like what a waste of time, bunch of paperwork. This is bullshit. And and then I'd ask if you were having an operation, would you want the checklist? 94% did.

And the reason why is we all have the Lake Wobegon syndrome. We all think feel we're above average. We would, you wouldn't be a surgeon. You wouldn't be in your, you wouldn't be on a SEAL team if you did not think I have my stuff together. And and that I can do it. You, you can't be great at this. If you don't have that self-confidence and you can't really be at the top, if you also don't have the humility to recognize that, that you still are constantly learning and need the help of everybody else to work, to get to where to go and to take advantage of these kinds of things.

So much of the profession bought in there was. A significant chunk who really saw it as a threat to their control and autonomy and others who felt it was a way for them to use these tools to say, you know, cause one of our rules was when you put this in your hospital, change the checklist, it should fit what you guys need.

You should drive how the system works based on what you were trying to accomplish for the patients. And, and many people felt it gave them control over the environment and having the environment function the way it needed to. It's it's, it's an ongoing cultural struggle.

CHRIS: Just a quick comment and then I know Stan wants to follow up, but the, so no question here, but it, it, I remember distinctly my time in the service that the SEAL teams are it's a great unit very dynamic and their thinking, et cetera, but that can come at a cost of not quite enough structure at times.

And I remember sitting in an ops center one night. And you know, we have all these overhead feeds. So, you're watching units all over the place in these little black and white you get to, you can interpret it pretty, pretty easily after time. And I remember sitting with a young officer and we were watching an army unit, one of our sister units who were equally fantastic at stuff on the ground, but they were about to load onto a helicopter.

And I said, watch what's about to happen. This is one of our shortfalls. And this is, these are, you know, 20 year plus experienced operators. And as, as the helicopters come in, they get in these nice little rows. It sounds silly. Right. But you can see it just like a kindergarten class getting ready to get off the bus and they're on their helicopter in perfect order in 12 seconds.

Right. And our helicopters land, cause we're all like Wobegon. We just sorta, we used to call it the mad dash. Right. Everybody just kind of figured it out on their own. Which is fine, 97% of the time or more, but it's that knowing when should we put in just that extra little bit of structure that we think is uncool, but it'll actually help us at the times that we least expect it.

DR. ATUL: Well, let me ask you, or, or General McChrystal, what, what is the culture of a SEAL team? Is it the cowboy or is it the pit crew? Or is it something else?

CHRIS: I'm going to ask Stan to answer that actually, cause I'm obviously biased. He oversaw all these different units and had the best perspective on the strengths and challenges maybe that each one faced.

STAN: Yeah, exactly right. Externally, a Navy SEAL team or platoon exhibits, this cowboy attitude. And when you walk up, they want you to see that, but that's not what it is at all. And I used to joke with him about it. I said, if I went into your drawers now and opened them, everything would be folded.

Everything would be cleaned and ready. You can't help yourself. That and of course, but there was this external idea, they want to be viewed as pirates, but, but absolutely they're extraordinarily disciplined. And then the other thing is this idea that being part of that team is so important to them that they're willing to subordinate a lot of other things, so that they are

maintained that connection to the team. And of course, it's the leave no man behind cultural whatnot. So, it's extraordinarily powerful.

DR. ATUL: I I'm reminded, I got on a, I was on an airplane flight and I sat next to a real live cowboy. And I was like, Holy, tell me about how you do your job.

Like, how do you move hundreds, hundreds of cattle across miles and miles of terrain. And, and he did begin to describe, well, you have, you have all of the different cowboys. They all have different positions they're in. You know, and we have and, and, and, you know, we, we are in constant communication and we have a game plan for how we're gonna be able to move forward.

And, you know, we have our protocols, we know what to do with a, if, if one of the cattle become sick. You know, here's what happens. Here's, here's our processes. This is what we do here, here, you know, he was able to why he walked me through the inoculations they give and the medicine treatment. And there we go, and the cowboys had checklists. The cowboys were a pit crew.

STAN: I love that I'm going to hit something real quickly before I move to another subject. And that is communication between doctor and patient, because we mentioned the number of surgeries. I had, one of them, I was, I had severe complications, spinal fluid leak, and these horrendous headaches.

So, it became an emergency situation. And my wife and I went in and, and it really was terrifying because the doctor, a Navy captain said, "I'm frankly, not sure exactly what's causing this and I'm not sure I can fix it." And the term he used, he goes, "it's not a chip shot, but I do need, I do need to tell you, I need to get in and try."

And, and literally my wife of many years, we're there and we're frightened out of our wits. And I asked him a question that I'm proud of now because I looked at him and I said, okay, doctor. If I was your wife, your wife, or someone you cared about and they needed this operation, would you have you do it?

Meaning? And I was asking him, are you the right person for me to put my fate in your hands? And this guy named Chris Neil, he looks at me. He says, I am. And as soon as he said that I knew he was right. And of course, he did it and it came out right into the great story, but I would never have asked that question eight surgeries earlier, you know, before, when I was younger and didn't know it, cause I, I would kind of walk in and so that relationship is different, but now I'm going to raise the airplane to 30,000 feet and I'm going to talk about medical care, writ large.

When Dwight David Eisenhower was given command of forces for the invasion of Normandy, he was given an order that said, you'll enter the continent of Europe and destroy the armies of the third Reich. Pretty straightforward. I got that. It's clear. And yet we have just faced a pandemic. And I feel as though the nation never had a clear mission statement.

Never really understood what we were trying to do and what each of us should do. So, I'm going to ask you with the benefit of some hindsight and all your wisdom. What should we have done? Take us back to December 2019.

DR. ATUL: I think you already named it. The single most important tool that we have in healthcare and in public health is communications. And the fundamental aspect of communication is communicating coming to clarity and agreement to the best you can on what the priority is that you're trying to serve. And then connecting your assets, your capabilities, the limited knowledge you have to to that priority. And we didn't do that in this pandemic in the United States. The countries that did do that, did the best.

There's no question that our, our failure to come around, the notion that we were going to commit to fighting the virus that, and then, okay. Great. It's clear. We are fighting the virus. We're not denying that the virus is a problem. We're, we are at minimum we're acknowledging that there's a major concern.

This could be a big problem, and we want to we want to address it and then go from there. Then, then the decisions changed over time and very rapidly early on, you had no information, but but there was, you know, the ability to the sequence for the virus had been released by mid-January from China.

I wish it was even sooner, but at that point you can make a test. South Korea agreed as a group of political leaders, we are concerned and we're going to address this problem. And step one is we got to know whether it's here or not and how to address it. And within five days they had test manufacturers, their clinical laboratories, developing tests and actually, you know, within, within five days of having their first meeting, they actually had the development of their first tests and approval by the equivalent of their FDA.

They said, this is urgent. We are going to move. Within a few weeks they had dozens of labs with tests ready to go. We didn't do that. We, we, we were in a place where it felt politically treacherous to even acknowledge that this could be a danger. And you've seen, I've seen in surgery, you've seen in your lines of work happens when you when, when it becomes wrong to acknowledge that something terrible might be going on for fear that, you know, I might upset the patient, or I might hurt the economy.

And you, you know, your surgeon gave you the, his honest assessment that he was very concerned. He thought this could be solvable, but this could be, this could be a very dangerous situation for you. And that was exactly where we were. And we were in need of that straight talk and then alignment between those the scientists and the political leaders around around what the knowledge is and what it is showing us over time. That early stage, then things changed as you got more knowledge about the virus and how it behaved. By April, probably even, actually by late, late March, it was very clear, a mix of, of some very straightforward things.

Masks, avoiding big crowds indoors, and maintaining some distance that these things could potentially work. And, you know, first we locked down, but then as we came out of lockdown, we've had the tools in our hands to, to avoid going back into a lockdown since then.

CHRIS: One of the you know, the the teaming model that Stan McChrystal is rightly credited with putting into the special operations community, sort of this global connectivity and network-based model of connecting people to share information so that you can move faster.

One of the very strong second order effects of that sort of approach is access to frontline, accurate information. So, I, a few thoughts here, and then I'd just be curious, your reaction, if you think of the, the challenger explosion in, in 1986, there's an engineer Roger Boisjoly, I think who was is credited with trying to explain to senior leaders, Hey, this, this O-ring won't survive at this temperature.

And he knew it was gonna explode and he just couldn't couldn't convince folks. So given the last year, I'm curious for someone with your expertise, when did your radar start to go off you and your peers? What, what were those key triggers that you were seeing and is part of our lesson that we need better pathways for those subject matter experts to be able to speak more loudly to the right leaders and, and somehow cutting the politics, et cetera that you just mentioned out of the way?

Is there a way to do that in the public health care space?

DR. ATUL: Oh, well, I was in the middle of the pack, I would say. So, I had colleagues who, I mean, as early as late December said, this thing is alarming in Wuhan. By late January in my own hospital, I had colleagues developing a coronavirus test.

And others are like, that's crazy. You know, we have other things we gotta put resources on, within my own hospital. And, and, you know, that was being replicated across the country. I think one difference in this in what was emerging was, this was such an instantly global discussion, that people were able to get their voice out to say we should be doing X.

And also, we're empowered to take action early like developing a test. Or you know, Mayor London Breed in San Francisco on March, I think it was sixth, very early, before San Francisco, I think San Francisco might've had its first case or might not even had its first case.

Already said, you know, I want businesses to consider if they can work from home, work from home. I want to have testing, you know, I want a testing plan to develop. I want to do X, Y, and Z. So, there were some early actors who could begin moving forward. The challenge in our environment was that when you have the leader committed to not raising those voices, not bringing resources their way, you can have a San Francisco doing well, but a Boston and a New York that are behind the eight ball. You can have a set of test developers who are ready to go, but no one tapping them, no one giving resources and actively telling them we do not want you deploying what you're developing. I mean, that was the direct message.

I had an email, you know, where my lab director was sent a letter by HHS telling them that they were to stop working with live virus and, you know, he did. And that was important. That turned out to be important when two weeks later, everyone changed their mind and said, you know what? We need to test after all.

And, and so the, there is, I would say your bottom line is true. We need to have those channels to open up. I think the public health and the healthcare sector is one in which we are very, data-driven, we're very open to having, you know, many public forums to discuss crazy ideas. And we have lots of folks able to bring those out and you can see, you know, where thinking emerges.

I was an early critic of the CDC and WHO's commitment to masks and persuaded many people in the hospital sector that we should have universal masks on everybody in healthcare and our patients. And that was a big part of the reason, not just me, many others, but that, that commitment was a big part of the reason why U.S. Hospitals were not the sources of the outbreak, like they were in Wuhan or in Daegu, South Korea or in, or in Northern Italy. But the larger level leadership, are we going to bring resources? Is this going to be a national commitment to fight the virus or, you know, Pearl Harbor has arrived. And you know what, we're going to have a different plan on what we're going to do about the Japanese attack.

You know, city by city, state by state, some places will raise an army. Some places will say, ah, the Japanese aren't going to come, aren't going to invade. Or if they invade it, won't be so bad after all, you know, that was the mess. That was the real mess.

STAN: Wow. I'm reminded, Atul of when Chris and I were in Iraq in the early days of the war in the fall of 2003, early 2004.

And you couldn't use the word insurgency, nor could you refer to it as the Iraq war because people were saying, no, it's something else. And yet they're shooting at us. We're shooting at them. You know, to me it looks like a duck and it walks like a duck, it's a duck. But this gets to trust. You know, we go back to the legacy of the Tuskegee study, the tragic decision, not to provide care to some people who needed it just to see what happened.

And now we've got a new experience that, that that's right. Exactly. To a very specific, and so we undermine trust in that community, but then the idea of undermining trust more broadly as you just sort of outlined when the narrative, isn't entirely honest. How do we assess trust with our medical community?

So can we can do effective things like public health and how do we increase it? How do we build it back?

DR. ATUL: Yeah. You know, one of the interesting things is that in this pandemic I think that trust in scientists and in the medical profession has grown even as trust in the specifics has waned it to some extent. You know, the enormous divide over whether masks work or whether one treatment is sound or not sound.

There, there are setups for exploitation. And part of the setup is when you have, I wrote an article some time ago about comparing the discovery of anesthesia and the discovery of antisepsis in the mid 19th century, the two big things that dramatically changed surgery. And when, when a surgeon demonstrated that using this gas, ether two could, could provide protection against pain for patients. That spread within weeks within weeks to every capital in Europe, to the major cities of the United States.

And within six years, there was not a hospital that was not providing anesthesia as part of surgery. When Lister showed that antisepsis could stop the biggest killer, which was infection. You know, broken bones killed people in those days when you had a compound fracture and because infection would set in, and the ability to treat people with, with basic antiseptics was critical to stopping that.

And he proved it could make a difference and it took more than a generation before it came before it spread, before it became part of what we do in healthcare. And the two big differences were that one resolved, a visible problem with an immediate effect. You could stop pain immediately with anesthesia and the other was an invisible and delayed effect.

And you, you know, infection is bacteria. You don't see them, the actions you take now, the infection doesn't actually kill you for two to three weeks. And so, you've disconnected my actions from what happens. And so, problem, number one, this pandemic is more like the second one. And often most of our most difficult public health issues are all about, you know, addressing blood pressure, smoking. An invisible effect now for a gain, a big gain later. Climate change falls exactly into this category.

But the second thing that compounded the problem was that address, bringing on anesthesia was not only good for the patient. It was good for the implementer, for the doctor and the nurses, because nobody liked taking care of a screaming patient. You had to pin down with three orderlies' operations typically lasted 60 to 120 seconds.

Cause that's all you could do, you know, to do an amputation, to do cataract removal, whatever you name it, because you just don't have much ability to, and, and, and it was, you know, you don't have much control. You can be meticulous. Surgeons loved anesthesia. They were the ones who drove it and sold it.

Contrast that with antisepsis. The antiseptic solution that Lister was trying to sell, it's kind of like Listerine. It was, it hurt, right? He, he tried to sell the, you know, it was carbolic acid dilute, carbolic acid is literally pain now, for someone else's gain later. And this pandemic, the other damning thing about it is 76% of the spread comes from people ages 20 to 49. And 93% of the deaths, are in people ages 55 and up. And so, we need pain now, and it is major pain, right? Kids not going to school. You're not going to work. Restaurants, bars, our lives changed. For the sake of the population of people over 55. And then you add in the people who have, you know, to, you know, have comorbidities that, that make up, make up the remainder.

And, and that is a, that is a, so the distrust comes because you got a choice in this situation. I can tell those folks 20 to 49, it's a lie. This is just a flu. You do what you want. They are trying to deny you. And the only way to fight that and, and you know, what comes out of it is then, well, what's your science versus my science.

My science says, you know, the constant thing I hear as well, everybody has their own data, has their own facts. And I think the thing we have not learned is how do you recognize fake science? Pseudo-science from the real science. And there are a few hallmark moves that people make that they will say it's a conspiracy to suppress descending views.

They will have fake experts with contrary views, but no credible scientific track record in the field to build on. They will be cherry picking data and papers to discredit an entire field of experts. You have to imagine that all of the experts are, are, are, you know, the majority are off in a different direction.

And and, and there are other things that they do now. We all have examples where there was a conspiracy or there that an expert out of the, out of the left field can turn out to save the day. But when you see it all put together, that's the pattern we have. We are not teaching the American public to recognize that, you know, maybe there is a conspiracy.

Okay. And there was in Tuskegee, there was a conspiracy. But then, you know, is there an, what, what are the experts saying about it? And experts came out and exposed Tuskegee. Experienced infectious disease doctors said it was crazy that we took black people in the South and let them experience syphilis and said, don't give them penicillin.

Credible people said that that was not a way to go, you know? The, when you see the combination of conspiracy, theorizing fail, all that mix. That's when you got it, that's when you should run. And, and we are, we need to talk about that pattern.

CHRIS: At this sake of running a bit over here. That's, it's just it's such an important point.

I'd love to ask you one last question and, and it's in the area of what, we'll come through this with, with good lessons. We're all have this optimism bias when we look behind and we'll forget some key ones. When now as just a civilian just observing the national security space. My steady drum beat concern is that we forget.

That you want to use kinetics as a last measure? Cause it's always bad for everyone. Sometimes it's unavoidable and you will, the best way to avoid that is remembering that it's all about people. You have to stay connected with the people in regions that you, if you're worried about future conflict.

You abandoned Pakistan; they're not going to be your friend next go round. We forget about Yemen and withdraw too fast, there's going to be long-term problems. There, there are real people on the ground, and we will forget that. In counterinsurgency, you have to learn that lesson or you won't survive literally. But as we drift away from that, we will forget that lesson.

And I watched that with a cautious eye. In this environment, what is, what is the key or key lessons that you, you hope we remember for the foreseeable future?

DR. ATUL: You know, honestly, it's the same one. It's the, you, you just described my whole ethos, which is that the individual matters. And that the truth is at the level of acknowledging what is the real lived experience on the ground.

It's paying attention to what the, what, what is happening to real life people. You cannot sustain the view that this is just a flu, that the tests are fake, that the XYZ and sit there. In my hospital, as

we got hit in Boston and, you know, we, we suddenly had three times more people than we had ICU beds who were, who could not breathe, who could not breathe.

You know, you cannot sit there right now and and recognize the importance of masks and imagine being in a hospital and taking off the mask and thinking that anything would be better about that. I love about medicine is you cannot afford to ignore the people. You cannot afford not to acknowledge the person's pain in front of you and suffering.

And when we have gone wrong, it's always been when we deny that. When we want to not acknowledge the suffering.

STAN: Hmm. Wow. Atul, it falls to me to, to wind this up and thank you. About 30 minutes ago, I asked you when searching for a doctor, should I be looking for a really good mechanic or a thoughtful leader?

And you made a good argument for thoughtful leader. And in the last 30 minutes, you've made an absolute example that you are exactly that thoughtful leader. So, when I go for number 11, I'll come see you. But when I want,

DR. ATUL: So, I'll tell you I'm not the right person for that orthopedic operation.

STAN: Thank you for your generous time today. But also thank you, what you're doing for the individual in our country and for our nation.

DR. ATUL: Well, thank you. And you know, you all who listen to them, know about what the General and Chris are doing to help those of us in public health, I've tapped and called on them to speak to States I'm working with, and they are working at every level with cities, states, and national level, providing advice and guidance on the ultimate moment that needs a team of teams and, and, and this new kind of leadership. So, I, I feel I'm doing this because I owe you guys.

CHRIS: Thank you.

STAN: Thanks so much.

CHRIS: So, exceptional discussion with, with just an amazing individual in Atul Gawande there. Who you and I've gotten to know a bit and before that obviously consumers of what he had written?

And I guess my biggest reflection was you kind of want to hate the guy, right? Cause he's, he's, he's a cross-functional thinker. He succeeds in so many different areas, but low ego, thoughtful, you know, just the nicest person, but just tireless in his focus. Which is just impressive. And, you know, he's just someone you can really learn a lot from and respect for what he's done.

One of the, and I shared it a bit in our discussion, but I remember when I was working on your staff, I was maybe, I don't know, eight or nine years into my career, and you're the first senior leader you're reading some business book, I can't remember what it was, you know, a biography about an industry leader.

I remember you telling us as your staff members, like you should be reading leaders from other spaces, not just military history, political history, because they have a lot to offer. And that really stuck with me. And I remember because you can't-- leadership, you can learn across sectors in a way that It takes a lot of us longer to realize that then than it, than it should.

And I read Gawande's checklist manifesto as I recounted our discussion when I was an operations officer in a combat zone. And just, there were so many learnings from that and he was talking about why checklists save lives, take complex things, break them down, wherever you can into simple steps. And it gives you white space to think about the more complex stuff.

So, a fascinating history. And it was one of the first going off of your advice, it was one of the first ones that I read by an outside leader that I said, oh, this is exactly transferrable. We just need to figure out how to map some of this. And I literally changed some functions inside the op center in that three- or four-month period, having digested some of that.

So, for me, that was one of the big takeaways. There's so much to learn by leaders in different sectors that you might not be, might be obvious right out of the gates.

STAN: Particularly when you can see both the micro and the macro. As you remember, this is about the one-year anniversary of me coming out of the hospital after a series of three spine surgeries in three different hospitals and extensive time in the ICU of each.

And so in each occasion, I had a surgeon work on my spine and that was very important, but I was obviously out during the procedure. So, I had to trust what happened there. But then as I watched the overall system, first the competence of that surgeon in getting the job done because I had so much fused, but then the next part was the teams that took care of me in the three hospitals.

And I learned that 99% of my actual interaction was with the teams. You had a very small amount with the actual surgeon and how well do they communicate? What is their level of discipline, just to do things right? There in one hospital, I found I had to lecture the team to communicate with each other because they were trying to get me things that I wasn't supposed to have and whatnot and others were, were tightly bound.

But Atul seemed to understand that in the operating room, you had to have a disciplined procedure to do things the right way to avoid, you know, unexpected mistakes. But then in the overall system, it has to be a combination of this discipline, but also this very people centric caring because at the end of the day, it's all about the person who is the object of the exercise and that's the human being and it is being mortar book.

Of course, he captures this sense of humanity of what happens in life. And so, he seems to have a really good sense of healthcare as a system and health as an individual thing we possess or don't.

CHRIS: Well, yeah, and it's a really interesting for someone like Atul who, who grows into a leader in a space that, and he admittedly said we don't teach leadership in medicine. I mean, it's, that practice is getting more and more common as people are starting to realize that that there's

multilayers and there's a there was a leadership role in the healthcare space. Not just at the tactical. But interesting to see somebody sort of self-taught and learned that through his own observations.

And curious your thoughts because I think it will matter to some of our listeners. You've worked with such a wide range of leaders. I can think of leaders that I worked for in the military that you had had groomed up underneath you. Who became, I don't know if they became, they seemed like these multi domain and strategic to tactical level thinkers.

They could throw on their body armor to go on an operation, but then flip around and brief the strategic very clearly and do that across different functions. So, they knew that the tribe they were talking to at any given moment. Any things you learned or have learned throughout your career to identify those folks early on and see that talent before they maybe have even recognized it in themselves.

STAN: Yeah, I'm glad you use the word identify because I think it is more identified than created. I don't think you can take a large group of people and expect to find a majority of the people that way. Frankly, I hired you because that's exactly what I saw when you were in 0-3. You're 0-3 in combat asking, 0-5, 0-6, and 0-7, that's Colonel level, then general level of questions and most of your peers won't do. And weren't doing that. I've even known some people who are very senior.

I knew one army, four-star general came down to inspect this big exercise we were doing when I was a Corps Chief of Staff, and I'm trying to find the guy. I was the Corps Chief and as a Brigadier General. And he's crawling under a heater, which was a portable heater that you put in tents in winter, looking for the model number on this thing. And I remember, and he's trying to say, you know, some of these model numbers, some of these are not good heaters.

We need to find the bad ones. And I wanted to say. General get up. That is not what you should focus on. We actually have big things out here. Maybe he was trying to show me attention to detail. I'm not sure, but yeah, the point is you've got to identify people who read more broadly. You've got to encourage it.

You got to have conversations. Sometimes people feel guilty if they're at work and they're having a conversation about something that's not directly associated with their product and their thing. Sometimes you got to talk about you know, very ethereal things because it expands you and, and that's the way you and I both thought about reading and and trying to study people ever since.

CHRIS: Yeah. It's a, it's a, it's certainly a takeaway. And I, I was, I was listening this morning to our discussion with Sam Kennedy on this podcast for the Red Sox and the, the reflection on, which obviously is near and dear to us, when you were talking about the headquarters in Balada, Iraq, where all of us have spent so many times so much time. There was a critical, I think it's one of the ways to groom that for, for other leaders to think about.

How are you pulling together those network leaders in your organization to be able to drive that culture? And when I think of that at its best, personally, for me, I think of that, that location, because when you walked into headquarters, when it was on step and there's, some of our listeners will have served there, you felt like you were in the Super Bowl.

Like you were surrounded by a critical mass of leaders that could do that, what you just described top to bottom, left to right. And you woke up just thinking I've got to be on my, A game if I'm going to you know, be in the same room with these folks. And so other organizations I think would benefit from thinking more deeply about who, who are those folks in my organization and how do I create that environment to pull them together?

I'm less worried about what they're talking about. I'm more worried about the influence they're having on the others to rise to that, that same level. So anyway, it was a, it was a good take away from me.

STAN: Yeah, I think Atul would describe the health care system that way. He wouldn't describe a hospital as a collection of individual nurses and anesthesiologists and surgeons.

He'd say it's this interactive team. And if it doesn't have the right culture and work, then it's nothing compared to what it ought to be.

CHRIS: Well, great, great discussion, with a great leader who now in his non spare time is going on to have to do great and important work in the COVID response, for our nation to not, not surprisingly finding the best place to put his mind, share, and time.

So, we appreciate him and his team and Atul, thank you for your ongoing leadership.