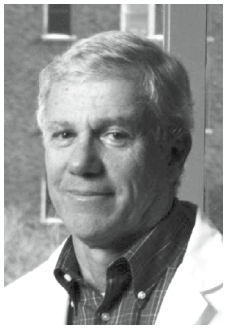
Interview with Dr. Allan Detsky

UTMJ Interview Team



Dr. Allan Detsky

Allan S. Detsky, MD, PhD, CM is the former Physician-in-Chief at Mount Sinai Hospital in Toronto, a Professor in the Institute of Health Policy, Management and Evaluation at the University of Toronto. He received his MD from Harvard Medical School and his PhD in Economics from MIT, both in 1978 and was a resident in Internal Medicine at the Massachusetts General Hospital from 1978 to 1980. He received his FRCPC in Internal Medicine in 1982.

Dr. Detsky's initial research interests focused on health economics, where he was quickly recognized as an expert and leader in the field. Some of his research involved resource management in ICU, evaluations of regulatory strategies in containing hospital costs, and early ventures into economic planning in the wake of the AIDS epidemic. In 2003, he completed a large study of the SARS outbreak in Toronto, and more recently has studied cognitive bias in clinical care and research. He has been a member of the Editorial Board of the New England Journal of Medicine and held a position as a Contributing Writer for JAMA for 10 years.

On June 29, 2018, Dr. Detsky was appointed to the Order of Canada, one of the country's highest honours.

UTMJ: Could you give us some background on your career trajectory?

ASD: I did my undergrad degree at MIT and majored in economics. Then, I started my graduate degree in economics at MIT. Sometime in my first year of grad school, I decided that I did not want to be an economics professor; the pace seemed too slow for me. One day I woke up and decided that I wanted to go to medical school, just like that. I had a very smart roommate (who is now the President of Harvard!) who said to me that he didn't think that anyone had combined a PhD in economics with an MD before. So he thought that I could apply to medical school with that unique package, and that is how I could get into Harvard. I went to the Harvard-MIT Health Sciences and Technology program where I was able pursue an MD at Harvard while also doing a PhD in economics at MIT. I finished both degrees in 1978 and did my residency at Massachusetts General Hospital in Boston. While I was an intern, Eugene Vayda, the Chair of the Department of Health Administration at the University of Toronto, offered me a position as an assistant professor, with a focus on health economics. I finished one more year of residency in Boston and then moved back to Toronto after an 11 year absence in July 1980. I had to complete one more year of my residency, which I did in two 6-month periods at TGH while I was not teaching. Then, I was appointed to the Department of Medicine as a Clinician-Scientist. A lot of my early work involved studying economic issues and hospital cost control, but I subsequently moved over more into clinical epidemiology. I then started to do research in "consult medicine", which is taking care of medical problems in surgical patients. The Detsky Index, a cardiac risk score for patients undergoing non-cardiac surgery, and Subjective Global Assessment of nutritional status were two major areas of interest in my early years at U of T. I also spent about 12 years working on the application of cost-effectiveness measurement to evaluate pharmaceutical products, working on the Drug Quality and Therapeutics Committee of Ontario during that time. The guidelines I developed were adopted by Ontario and in a modified form by the federal Common Drug Review panel, too. I then become very interested in conflicts of interest between physicians and third parties. After about 7 years of research, I was named the first Division Director of General Internal Medicine at U of T (and TGH), and I did that job for 9 years. I was then Physician-in-Chief Medicine at Mount Sinai for 12 years. In 2009, I left all of that and returned to be a faculty member.

UTMJ: How did you balance clinical responsibility with your other responsibilities throughout your career?

ASD: When I do clinical work, I do a month on or a month off. This means that I take care of inpatients for 28 days in a row, 24/7. This also means that when I do not do clinical work, I have no clinical responsibilities. When I started out as a scientist, I only did three and a half months of clinical work in a year, and most of it was on consult medicine, so it wasn't very taxing. I knew that if I didn't continuously keep up and talk about medicine every day, I would rapidly become a bad doctor; I would forget things, and I would lose my instincts. So I developed the Medical Consult Service Morning Report: every morning for 45 minutes, we would sit down and discuss clinical cases. I did this every weekday for 7 years to keep up my clinical skills. When I became Division Director, one of the older doctors mentioned that I was too much of a scientist to be Division Director. This motivated me, and I expanded my clinical

time to six months a year; three on general internal medicine inpatient team medicine and three on consult medicine. As Physician-in Chief at Mount Sinai, I did 5 months per year, all on general internal inpatient team medicine. This allowed me to maintain my clinical skills and responsibilities.

When I was Division Head, my "rule" (more of a very strong suggestion because it didn't have control) was that everyone had to do at least 3 months of clinical medicine every year to remain competent. Two years ago, I wrote an article about when you are the leader of an organization, the best thing that you can do is understand what goes on at the front line. If you don't participate in direct patient care, you are missing an opportunity. Physician leaders have an opportunity to do this, and they should. I think everyone can carve out some scope of clinical practice. If you don't understand on a daily basis what it is like to be a patient, and what it means to be a doctor helping that patient, I don't think that you have full perspective.

We did a survey of physician leaders across Canada and the United States about their clinical work. I don't have the results on hand at the moment, but my impression is that most do some practice clinical work.

UTMJ: You have experience in both the US and Canada. What do you think about the management of finances in Canada?

ASD: Aside from the elephant in the room, which is insurance status, the clinical setting looks exactly the same in the US and Canada. The pattern of rounds is the same, the language is the same, the coffee, the construction, the slow elevators – it is all the same.

We can spend as much money or as little money as we want on healthcare. As Irfan Dhalla so nicely showed in a paper in the CMAJ, there really isn't a problem of sustaining it. The reason that it isn't a problem is that the amount that we spend on health care is 12% of GDP, which means we are spending 88% on something else. People say that if the amount that we are spending on healthcare is growing at 8% per year and our GDP is growing at 3% per year, it will all eventually collapse and absorb the entire budget. This is false, because 8% of 12% is a very small fraction, while 3% of 88% is a much larger number. The paradox of looking at only proportions is that we don't realize that the absolute amount is growing a lot larger. So how much we spend or don't spend is an entirely political decision when healthcare spending is taken out of the hands of the consumer because of insurance. Conservatives who want to promote private medical care push this sustainability issue. They believe that there should be a two-tiered system: there should be a private sector which can act as an offload for the public system, lines will be shorter, and that is their argument. Liberals argue that if you do this you take the vibrant parts of society, which are those people that push the healthcare sector to improve, and allow them to migrate towards the private sector. What you are left with is a public sector that will not be driven as much to improve. This is a caricature of the arguments on both sides.

In the US it is both different and in many ways similar. What people don't realize is that the US does have a federal single payer healthcare system, Medicare. It has been a screaming success. It is not perfect, and there are experiments within it. They have the same pressures that we have, but they have a different political system.

UTMJ: How do you think that we are performing in Canada compared to other countries?

ASD: It all depends on your point of view. You can find lots wrong with it and lots right with it. Here is what is good about our system. Everyone who has legal status in Canada has a card, there a few barriers to get it, and the card lets you go anywhere in Canada and get medically necessary services. It doesn't cover everything, but it covers what was deemed to be medically necessary in 1968; physician and hospital services. As soon as I see their health card, I know that there are no financial barriers for the patient to receive care from me or my hospital. This makes everything administratively simple and allows most people who live close enough to health care centers to get most of the care that they need. It isn't perfect, however: there can be long waits, and not everyone lives in an area where you can easily access health care. We do all of this with 12% of our GDP. Our gains in life expectancy have been greater in Canada than in the US, and we spend a lot less than they do. Taiwan designed their healthcare insurance program after our program in Canada and I went to a celebration of 20th anniversary since it was adopted it in 2015. They asked me (and other attendees) what they could do better. Taiwan spends only 6% of their GDP on health care. I told them, if you can politically get away with only spending 6% of your GDP and deliver healthcare in a way that you don't get voted out of office, it is hard for us to offer advice; we can't do nearly that well.

UTMJ: When looking at published healthcare metrics, Canada does not perform favourably. How can we explain our performance based on the amount that we spend on healthcare?

ASD: It depends on which metrics you look at. If you look at wait times, Canada does not do that well, but if you look at access to healthcare, we do quite well.

UTMJ: What do you see as the biggest challenge to healthcare system in the next couple of decades?

ASD: I think the biggest challenge is the lack of continuity and coordination. When I was an intern in 1978, we did not have many things we could offer patients; many fewer drugs and far fewer diagnostic tests, espe-

cially in imaging. One of my classmates once said, "All we really had were good intentions." Now, there are a million things we could do for patients. Some of these are helpful, some only marginally. There are more tests to order and treatments to give. But healthcare has turned into silos of care. There are many different doctors in different specialties that look after patients, even in short periods of time. Continuity as we knew it is gone. In the old days, physicians and attendings were there for a month; currently most of the younger attendings serve for one or two weeks. Now, for a complex set of reasons, we have chopped inpatient rotations for residents so they are present on random days. As a result, even in the way we train our future doctors, the continuity of seeing the same person who knows the full patient's story is disappearing rapidly. There are good reasons why training schedules have changed, but when you put them all together, it leads to an attitude of "continuity is not a valued concept."

UTMJ: What solutions do you propose?

ASD: Someone has to recognize this. The Royal College has moved to competency-based design but have no evidence for it. They have mounted it based on public and personal opinion of key educational leaders. But it seems to me that nobody actually cares about the concept of continuity. If the Royal College dictated an emphasis on continuity in training (the way they have done so with competency-based evaluation), we would have continuity in training. Doctors are highly motivated by intrinsic factors, so I don't think the problem is a change in their work ethic or skill. It is the forces that determine how they are taught that have led to this predicament. The place where physicians realize this is when they or their family members become ill. Then they recognize the importance of continuity.

UTMJ: How to promote physicians to perform better beyond using extrinsic motivation?

ASD: You need to get the right mix of intrinsic and external motivators and be sensitive to the local culture. One mechanism is pay-for-performance (PPF) or value or quality-based reimbursement. For example: the Mayo Clinic is mostly ambulatory, and it is homogenous. They have managers that book their patients for them. They are told you work this many weeks per year, these are the number of patients you are going to see, and these are the concerns and expectations. The physicians get paid a salary. To get into that system, you have to buy into that and it is like a military environment because everyone is doing that. If you said to those doctors who are used to straight salary, highly-regulated work times, and a culture where everyone has to do the same thing, "We will pay you an extra $50 to get the HbA1c down to less than 7," they will laugh at you. They would say, what did you think we were doing before? PPF does not work in a culture like that.

In our culture in Toronto, we are mostly paid fee for service. Pay-for-performance for some aspects of care may work here. Pay-for-performance depends on the context and the history. Thirty years ago, our practice plan in the Department of Medicine at TGH paid everyone the same amount no matter how many patients they saw. We gradually made changes so that we rewarded people for seeing more patients and penalized if they did not make their target. Over time, these changes improved the productivity of our physicians. There is no one single answer for how to motivate people. The context counts a lot.

UTMJ: Can you tell us a bit about your personal life?

ASD: In 2010, my wife and I went to Stratford and saw a few shows there and we met an actor who ultimately asked me to produce his next record album. The next year he was cast at Judas in Jesus Christ Superstar, and we were invited to become producers when that show transferred to Broadway in 2012. Subsequently, we became involved in several Broadway productions: Annie, Matilda, Hedwig and the Angry Inch. In 2015, I went to a reading in Seattle of a new show about events in Gander after 9/11; my wife and I signed on to be producers for Come for Away and that has been an enormous success. I received my second Tony nomination for the best musical for our involvement in that show. Having a Toronto production of it has been a lot of fun for us too.

UTMJ: What would you say has been most integral to your successes?

ASD: When I designed my job, I did it so that I could spend most of my time doing things that excite me or as I like to say, things that make me get out of bed in the morning. I love to teach, I love to work with patients, I like finances and reports, and I like writing. I do not like phoniness or meetings where nothing gets accomplished. I spend time doing things I am passionate about. Having a passion for what you do is important. If you really like it, you will enjoy it. Design your job that way.

I am extremely efficient. I have good time management skills. I can accomplish some tasks very quickly. I try to "never touch the same piece of paper or read the same email twice."

Finally, I suggest having a family, no matter how you choose to define it. And spend a lot of time with them; figure out how to organize your life so that you can balance work with family. It's not impossible, you just have to be strategic. I have two sons, two daughters-in-law, four grandsons, and we finally had a granddaughter this year! As I have written before, when your career is over, you will have many people who remember you fondly. Make sure those include the members of your family.