Folks,

In the 23 Jan 2017 The New Yorker, Atul Gawande, surgeon, who writings have impacted this nation's thinking about healthcare, claims the United States devotes vast resources to procedures, while starving the kind of steady, intimate care that often helps people more. Excerpts from this article include:

Studies demonstrated that states with higher ratios of primary-care physicians have lower rates of general mortality, infant mortality, and mortality from specific conditions such as heart disease and stroke. Other studies found that people with a primary-care physician as their usual source of care had lower subsequent five-year mortality rates than others, regardless of their initial health.

Primary care physicians focus on the course of a person's health over time—even through a life. All understanding is provisional and subject to continual adjustment. Taking the long view means thinking not just about her patient's symptoms but about all of it—along with her living situation, her family history, her nutrition, her stress levels, and how they interrelated—and what that picture meant a doctor could do to improve her patient's long-term health and well-being throughout her life.

Success, therefore, is not about the episodic, momentary victories, though they do play a role. It is about the longer view of incremental steps that produce sustained progress. That, such clinicians argue, is what making a difference really looks like. In fact, it is what making a difference looks like in a range of endeavors.

There is a lot about the future that remains unpredictable. Nonetheless, the patterns are becoming more susceptible to empiricism—to a science of surveillance, analysis, and iterative correction. The incrementalists are overtaking the rescuers. But

the transformation has itself been incremental. So we're only just starting to notice.

Our ability to use information to understand and reshape the future is accelerating in multiple ways. We have at least four kinds of information that matter to your health and well-being over time: information about the state of your internal systems (from your imaging and lab-test results, your genome sequencing); the state of your living conditions (your housing, community, economic, and environmental circumstances); the state of the care you receive (what your practitioners have done and how well they did it, what medications and other treatments they have provided); and the state of your behaviors (your patterns of sleep, exercise, stress, eating, sexual activity, adherence to treatments). The potential of this information is so enormous it is almost scary.

Instead of once-a-year checkups, we will increasingly be able to use smartphones and wearables to continuously monitor our heart rhythm, breathing, sleep, and activity, registering signs of illness as well as the effectiveness and the side effects of treatments. Engineers have proposed bathtub scanners that could track your internal organs for minute changes over time. We can decode our entire genome for less than the cost of an iPad and, increasingly, tune our care to the exact makeup we were born with.

Our health-care system is not designed for this future—or, indeed, for this present. We built it at a time when such capabilities were virtually nonexistent. When illness was experienced as a random catastrophe, and medical discoveries focussed on rescue, insurance for unanticipated, episodic needs was what we needed. Hospitals and heroic interventions got the large investments; incrementalists were scanted. After all, in the nineteen-fifties and sixties, they had little to offer that made a major difference in people's lives. But the more capacity we develop to monitor the body and the brain for signs of future breakdown and to correct course along the way—to deliver "precision medicine," as the

lingo goes—the greater the difference health care can make in people's lives, as well as in reducing future costs.

This potential for incremental medicine to improve and save lives, however, is dramatically at odds with our system's allocation of rewards. According to a 2016 compensation survey, the five highest-paid specialties in American medicine are orthopedics, cardiology, dermatology, gastroenterology, and radiology. Practitioners in these fields have an average income of four hundred thousand dollars a year. All are interventionists: they make most of their income on defined, minutes- to hours-long procedures—replacing hips, excising basal-cell carcinomas, doing endoscopies, conducting and reading MRIs—and then move on. (One clear indicator: the starting income for cardiologists who perform invasive procedures is twice that of cardiologists who mainly provide preventive, longitudinal care.)

Here are the lowest-paid specialties: pediatrics, endocrinology, family medicine, H.I.V./infectious disease, allergy/immunology, internal medicine, psychiatry, and rheumatology. The average income for these practitioners is about two hundred thousand dollars a year. Almost certainly at the bottom, too, but not evaluated in the compensation survey: geriatricians, palliative-care physicians, and headache specialists. All are incrementalists—they produce value by improving people's lives over extended periods of time, typically months to years.

This hundred-per-cent difference in incomes actually understates the degree to which our policies and payment systems have given short shrift to incremental care. As an American surgeon, I have a battalion of people and millions of dollars of equipment on hand when I arrive in my operating room. Incrementalists are lucky if they can hire a nurse.

The coming years will present us with a far larger concern, however. In this era of advancing information, it will become evident that, for everyone, life is a preexisting condition waiting to happen. We will all turn out to have a lurking heart condition or a

tumor or a depression or some rare disease that needs to be managed. This is a problem for our health-care system. It doesn't put great value on care that takes time to pay off. But this is also an opportunity. We have the chance to transform the course of our lives.

Doing so will mean discovering the heroism of the incremental. That means not only continuing our work to make sure everyone has health insurance but also accelerating efforts begun under health reform to restructure the way we deliver and pay for health care. Much can be debated about how: there are, for example, many ways to reward clinicians when they work together and devise new methods for improving lives and averting costs. But the basic decision has the stark urgency of right and wrong. We can give up an antiquated set of priorities and shift our focus from rescue medicine to lifelong incremental care. Or we can leave millions of people to suffer and die from conditions that, increasingly, can be predicted and managed. This isn't a bloodless policy choice; it's a medical emergency.

Roger