

How Healthcare Revolutionaries Think

10 Questions with David Nash, M.D.

By David Burda
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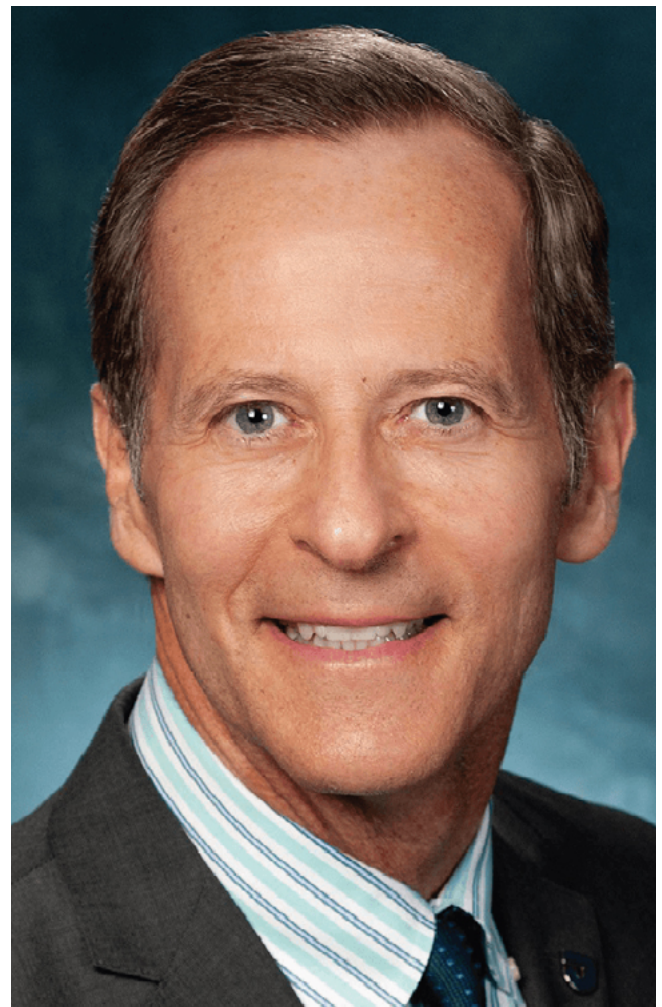
Welcome to the latest installment of 4sight Health's series, *How Healthcare Revolutionaries Think*. Our interview series profiles healthcare instigators who believe that outcomes matter, customers count and value rules.

Most of us healthcare watchers consider David Nash, M.D., to be the "father" of population health. Dr. Nash is the founding dean emeritus and Dr. Raymond C. & Doris N. Grandon Professor of Health Policy in the Jefferson College of Population Health at Thomas Jefferson University in Philadelphia.

Dr. Nash had a front-row seat to the COVID-19 pandemic not only as the father of population health but as the father of a physician daughter who served as a frontline caregiver to the pandemic's first patients when PPE was short, and our knowledge of the virus was even shorter. Thankfully, both Dr. Nash and his daughter survived the experience.

Dr. Nash captured that experience in a new book, *How COVID Crashed the System: A Guide To Fixing American Health Care*, which comes out in September.

I talked to Dr. Nash about what he thinks of today's healthcare system, today's medical students and if either is ready for tomorrow's population health challenges.



1

If we looked up “healthcare revolutionary” in your dictionary, what would the entry say, Dr. Nash?

Nash: To me, a revolutionary is someone who has a Trojan horse approach to change. They get inside the system and create change from the inside out. They do it through a combination of stealth, outliving their enemies and tackling the status quo head on. I’ve been lucky enough, I think, to be able to do all three in my 32 years on the faculty at Jefferson in Philadelphia.

2

Do insiders have an advantage over outsiders in trying to change the status quo in healthcare? If so, why?

Nash: Yes. There is that old saying that you can’t be a soothsayer in your own village. But I’ve always thought that insiders do, in fact, have an advantage. Why is that? Well, we know the secret handshake. We know the implicit and explicit culture. We know what color tie we’re supposed to wear. We know who sits at what part of the table. All those things are important because culture eats strategy before breakfast. I’ve always thought insiders have the advantage, especially in healthcare, where it’s been proven time and time again, even in this last decade.



3

Whose picture runs with your definition of a healthcare revolutionary in your dictionary?

Nash: There would be a few. [Brent James, M.D.](#), [Gail Warden](#), [Stephen Klasko, M.D.](#), and [Samuel P. Martin, III, M.D.](#) That's a pretty good list, and a list of some of the people who have had a great influence on me.

4

What's the common thread that connects your list of healthcare revolutionaries? If they all were in a room, what would they be talking about?

Nash: Well, first of all, the Heisenberg uncertainty principle would make it impossible to have them all in the same room at the same time. If that happened, the world would tilt on its axis, and we'd be in a new ice age. So that can't happen.

I think the thread that connects them all for me is that in their own time, they saw the future. They lived in the future in the present and made the future come alive. Let me give you a couple of examples. In 1973, Sam was talking about the need for physician leaders who graduated from medical school but also had another degree or credential after their M.D. When I met Gail, in 1990, he said he needed only three words to describe everything that's wrong with healthcare: unexplained clinical variation. Here we are 30, 40, 50 years later talking about the same things and trying to fix the same things.

They could see around the corner and tell people clearly what's around the corner and that they better prepare for what's ahead. They also have to convince people, that their vision is real.

5

Given your definition and your examples, do you think you're a healthcare revolutionary?

Nash: My physician wife of 42 years thinks I'm Don Quixote and that I've spent my life struggling against immovable healthcare windmills. Here lies David Nash. He really tried hard. But seriously, what matters most to me is the impact that I believe I've had on medical students of all sizes and shapes. It's all about the people whom I've had the privilege of teaching. I hope that will be my legacy. My enduring legacy. I hope that's what people will remember about me. My teaching and my enthusiasm for teaching.

6

What do you think your past, present and future medical students will remember about you? What lessons will they remember, or you hope they remember when they become doctors?

Nash: They're definitely going to remember my train whistle. I've blown that old train whistle to get their attention probably several hundred times in hospitals and at meeting around the country. That would be hard to forget. Seriously, I hope they remember my three main messages, which have been eerily consistent. One, if you're not part of the solution, you're automatically part of the problem. Two, the job of current leaders is to train tomorrow's leaders. Three, if you change the economic incentives, you change the clinical textbook of how we practice. Like I mentioned, the good news is that I've been consistent with those messages for more than three decades. The bad news is we're still talking about them, and there's no end in sight for any of them. We're still working to perfect all three.



7

When you connect economic incentives with how doctors practice, is that shocking to your medical students? Do they say, "Oh my God! I would never let money influence how I treat my patients."

Nash: I think clinical audiences, like medical students, they may smirk. They may roll their eyes. But they get it. So much evidence has accumulated over the years showing money affects practice patterns that they know it and can't deny it. When I say that to nonclinical audiences? They're still shocked. They say, "I thought you all read the same book? I thought you all studied the same thing and practiced the same way?" Many bright people outside of the healthcare industry think we're all doing a pretty good job and that there's not much difference between your hospital and mine. It's incredible to me that people still think that way, but they do.

8

What about your other messages? How are they received? Have they sunk in?

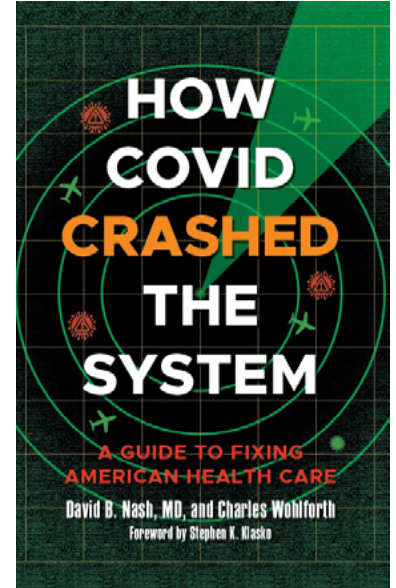
Nash: I'm still amazed that most doctors don't see themselves are part of the solution. It's woe is me. This is happening to me. Look at what they're doing to me. Aside from a modest minority, they all feel victimized. Without participating in the fix, they're just as guilty. That part is still pretty vexing to me.

On the other hand, technology has made the problem of unexplained clinical variations much clearer, and you can see how economic incentives can affect how a physician practices. Everything a physician does is recorded electronically. We know exactly what Dr. Nash ordered, when he ordered it and how what he did compares with his peers. You don't need a hammer to hit people over the head anymore. Now you show them the data in a non-punitive closed feedback loop and give them the training they need to improve. Doctors will stampede to improve if you do both those things — data and the training.

9

In your new book, you and your co-author Charles Wohlforth search for the root causes of why the healthcare system was so unprepared for the COVID-19 pandemic. What were some root causes and how would you rank them in terms of contributing to our lack of preparedness?

Nash: The first half of the book is all about what went wrong. The second half is about how we fix it. So, what went wrong? From a systems perspective, the answer is everything all at once. It would be hard to rank them. Every system is perfectly designed to achieve exactly the results it gets. Ditto for healthcare. There was no primary care infrastructure. There was no focus on population health. There was no focus on severity of illness or tiering who's sick or who needs to be seen. We rushed to get telemedicine and digital health platforms up. They worked if you had an internet connection or a cell phone. If you were poor and couldn't afford those, you were screwed. We were completely unprepared, and the thesis of the book is that we're still unprepared. We have deep structural problems that need our attention, and we better get to it before the next pathogen comes along.



10

Last question Dr. Nash. You've been doing population health for more than 30 years. You've made it through the COVID-19 pandemic. How did you react when you first heard the word "monkeypox" in the news? Did you shrug your shoulders, or did you spit out your coffee?

Nash: I fell off my chair when I first heard it on the news. We had a case in Philadelphia in early June. At the same time, it's totally expected. We're going to see other diseases, other viruses as we encroach on the global habitats of all kinds of creatures, big and small, and experience other environmental changes like climate change. We can't imagine what's coming around the corner, but it's coming. That's why it's critical that we learn the lessons from the pandemic and start putting the right systems in place now.

BURDA'S FINAL BIT

I've known Dr. Nash for years. I've heard him speak many times and interviewed him for stories that I've written. Dr. Nash is, as us journalists like to say, a "big boy." He tells it like it is. He's not flustered by any tough questions. He's candid. He's direct. If he wants something, he'll ask for it. If you say no, he's cool. He doesn't sweat the small stuff. He's been preaching population health before they called it population health, and he's still as passionate about the topic as he was more than 30 years ago. Dr. Nash knows he's right. We know he's right. But if we want to rebuild the healthcare system to better serve patients by keeping them as healthy possible, we really should start doing what he says.

David B. Nash, M.D., M.B.A.



Dr. David B. Nash is the Founding Dean Emeritus Jefferson College of Population Health (JCPH), and he remains on the full-time faculty as the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy. His 11-year tenure as Dean completes 30 years on the University faculty. He still serves the university as “Special Assistant” to the Chief Physician Executive, and as a board member of Jefferson’s ACO.

A board-certified internist, Dr. Nash is internationally recognized for his work in public accountability for outcomes, physician leadership development, and quality-of-care improvement. Repeatedly named to Modern Healthcare’s list of Most Powerful Persons in Healthcare, his national activities cover a wide scope. Dr. Nash is a principal faculty member for quality-of-care programming for the American Association for Physician Leadership (AAPL). He served on the NQF Task Force on Improving Population Health, The Joint Commission Award Committee, and is a founding member of the AAMC-IQ Steering Committee, the group charged with infusing the tenets of quality and safety into medical education. Dr. Nash continues to serve in governance roles for organizations in the public and private sectors, as he has throughout his career.

Dr. Nash has received many awards in recognition of his achievements, and his work is well known through his many publications, public appearances, and online column on MedPage Today. He has authored more than 100 peer-reviewed articles and edited 25 books, as well as holding editor roles at industry publications including *Annals of Internal Medicine* (1984-1989), *American Journal of Medical Quality*, *Population Health Management*, and *American Health and Drug Benefits*. His next book, *How COVID Crashed The System: A Guide to Fixing American Health Care*, will publish by Rowman and Littlefield in the fall of 2022.

Dr. Nash received his BA in economics (Phi Beta Kappa) from Vassar College; his MD from the University of Rochester School of Medicine and Dentistry and his MBA in Health Administration (with honors) from the Wharton School at the University of Pennsylvania. He has received honorary doctorates from Salus University in Philadelphia, GCSOM, and the University of Rochester, delivered numerous endowed and named lectures across the country.

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Dr. Nash recently co-authored a **4-part series** on Overcoming Medical Orthodoxy with David W. Johnson.

- [Part 1: Dysfunction in Medical Education](#)
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AUTHOR



Dave Burda began covering healthcare in 1983 and hasn't stopped since. Dave writes his own column, "Burda on Health," for 4sight Health, contributes weekly blog posts, manages our weekly e-newsletter and weekly podcast, 4sight Friday and 4sight Roundup. Dave believes that healthcare is a business like any other business, and customers — patients — are king. If you do what's right for patients, good business results will follow.

Dave's personal experiences with the healthcare system both as a patient and family caregiver have shaped his point of view. It's also been shaped by covering the industry for 35 years as a reporter and editor. He worked at *Modern Healthcare* for 25 years, the last 11 as editor.

Prior to *Modern Healthcare*, he did stints at the American Medical Record Association (now AHIMA) and the American Hospital Association. After *Modern Healthcare*, he wrote a monthly column for *Twin Cities Business* explaining healthcare trends to a business audience, and he developed and executed content marketing plans for leading healthcare corporations as the editorial director for healthcare strategies at MSP Communications.

When he's not reading and writing about healthcare, Dave spends his time riding the trails of DuPage County, IL, on his bike, tending his vegetable garden and daydreaming about being a lobster fisherman in Maine. He lives in Wheaton, IL, with his lovely wife of 35 years and his three children, none of whom want to be journalists or lobster fishermen.

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