What Matters in the End

An interview with Atul Gawande by Krista Tippett

Atul Gawande practices general and endocrine surgery at Brigham and Women's Hospital in Boston. He's also professor in the department of health policy and management at the Harvard T.H. Chan School of Public Health, and he's Samuel O. Thier Professor of Surgery at Harvard Medical School. He was recently named the CEO of Haven, a healthcare venture spearheaded by the leaders of Amazon, J.P. Morgan, and Berkshire Hathaway. He's been a staff writer for *The New Yorker* magazine since 1998 and is the author of four books, including *The Checklist Manifesto* and *Being Mortal: Medicine and What Matters in the End*.

Atul Gawande grew up in the Appalachian foothills of rural Ohio near the West Virginia border, feeling more than a little out of place with two Indian immigrant parents. When we spoke in 2017, he described an early life steeped in the Hindu practice he still calls defining for his identity.

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Krista Tippett: What does a good day look like? This is the question that transformed Atul Gawande's practice of medicine. He's a citizen physician on frontiers of human agency and meaning in light of what modern medicine makes possible. And for the millions who have read his book *Being Mortal*, he's also opened new conversation about the ancient human question of death and what it might have to do with life.

Atul Gawande: The conversation I felt like I was having was, do we fight, or do we give up? And the reality was that it's not do we fight, or do we give up? It's what are we fighting for? People have priorities besides just surviving no matter what. You have reasons you want to be alive. What are those reasons? Because whatever you're living for, along the way, we've got to make sure we don't sacrifice it. And in fact, can we, along the way, whatever's happening, can we enable it?

Ms. Tippett: I have actually found it's very hard to speak — I think this is true in general of religion, that it's hard to speak about it — but I think that that's true especially with Hinduism because it is so much about practice. It is so wide-open. It's not ideas. Do you know what I mean?

Dr. Gawande: Yeah, it's so embedded in the culture. The line between how do you treat your mom and your dad and how are you supposed to grow up and your ways of praying — it's seamless. It is not easy to separate it. For example, I grew up that you never put your foot on a book, because a book is spiritual, and it's wisdom, and it's meaningful. So if I ever put a foot on a book, I had to apologize to the book, put my hand on it and apologize. I grew up doing that, and I cannot, to this day, put a foot on a book. It's just sacrilegious. It is dishonoring not only the

book but everything that matters behind it. And it's inseparable. It's a way of living and a way of praying, I suppose.

Ms. Tippett: It's a whole different way of putting the words "sacred" and "text" together too.

Dr. Gawande: Yes.

Ms. Tippett: I love that. I have read you for years, but somehow, I had never picked up — I was fascinated to learn that you actually wound your way into being a surgeon through politics. And I wonder, do you think of the doctor in you and the part of you that was drawn to politics and campaigns and policy and process — are those two different sides of you, or do you have a sense that these things are intertwined?

Dr. Gawande: I feel like they are not separate. They feel very intertwined. I'm still getting my feel for how I think about it that way. One way was, I grew up in a family of doctors, and there is a certain way of being part of the community that I grew up with. My parents, in a rural town in Ohio, were very much part of the civic life. They were members of the rotary club. My father became the president of the rotary club, and then my mom, as soon as the ban on women being president of the rotary clubs, as soon as that lifted, she challenged locally and became the president of the local rotary club.

That sense that you are, as a clinician, a physician, part of the community, that you're contributing, has always been there. What I love about medicine is the idea that it has this core, thousands-year-old commitment to the idea that all people have equal worth and deserve equal dignity and that we're enacting that and trying to serve that every day. But that has larger connotations than just whether you are getting the same surgery that some mucky-muck is getting.

Ms. Tippett: This whole matter of our mortality, I was looking at the — just thinking about the title "Being Mortal" and the fact that that is a fact, that being alive is a fatal condition, that we all do have a diagnosis that we will die, and that you just experience again and again and write about how — and yet, that people are almost always surprised. It's just so fascinating about us. And do you think — is it that we don't let it into our consciousness, that we haven't gotten to the point where we can, or that we resist that?

Dr. Gawande: I dove into that topic because I was as confused about it as you are. First of all, I didn't know what it meant to be a good doctor for mortal beings, the question of what does it mean to be competent with people who are going to have problems you cannot fix? And also, how do you become competent and great at it if you don't know whether the problem you're dealing with, with certainty, is one they're going to die from or not? And the situations that disturbed me the most were ones where someone would come in, they'd have a condition that I knew was incurable, a terminal cancer, but we don't know, is it going to be a year? Is it going to be three years? Is it going to be five years? And therefore, we start trying —

Ms. Tippett: And that bar keeps moving all the time now.

Dr. Gawande: That's right, we have new technologies, and so we're going to start trying stuff. And then I have so often been there when we said, "Let's try that one more thing." And they're in a bad situation. And we say, "Should we try surgery? Well, yes. We have to give it a try," and then they never wake up again. And then you see the suffering that has come from that, because we never once talked about the fact that their life might be mortal — is mortal. I didn't even know how to begin to have that conversation, and they never woke up. They spent the next couple weeks in the ICU, and then we unplugged the machine. They didn't get to say goodbye. They didn't get to say, "I love you." They didn't get to say, "I'm sorry."

And the families, I see that they're tortured, but then you see, also, when people have those kinds of endings — six months later, families are more likely to have PTSD symptoms and depression. And what I realized is, we were not really talking about death or dying. We were really talking about how do you live a good life all the way to the very end, with whatever comes? That's what you begin to unpack.

Ms. Tippett: And that's such a different question than "How do I fix this? How do I cure this?" I've spoken to so many people, across the years, who were there at the advent of the hospice movement or have been involved in that. You even write about that. Even when you were becoming a doctor, when you were going through your medical training, it was about how do I fix this? And then death was a failure and that at the point at which somebody was definitely going to die, medicine stopped.

Dr. Gawande: Yeah, that's exactly right. The conversation I felt like I was having was, do we fight, or do we give up? And the reality was that it's not do we fight, or do we give up? It's what are we fighting for? People have priorities besides just surviving no matter what. You have reasons you want to be alive. What are those reasons? Because whatever you're living for, along the way, we've got to make sure we don't sacrifice it. And in fact, can we, along the way, whatever's happening, can we enable it?

Someone said to me, "I want to take my children to Disney World, my grandchildren. One thing I want to make sure I'm able to do is take my grandchildren to Disney World." She was telling that to me in the hospital, emaciated, on her last days. She would die 48 hours later. And we had missed that. We had failed. We had never asked her, to know that might have mattered to her, because we could have made that possible for her a month before.

Ms. Tippett: If those questions had been asked earlier?

Dr. Gawande: That's right. So it wasn't about do we fight or not? It's that we missed the fight. The fight was to make sure, among other things, that she got to go take her grandchildren to Disney.

Ms. Tippett: When you're writing, you're often — I feel like there are moments when you really are redefining the purpose of medicine as you learned it — well, in a very modern definition. But you said, "We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive." And it's not just about prolonging life.

Dr. Gawande: I ended up devoting a chapter to a psychologist from Stanford that it never occurred to me would be where the direction of the book would go. Her name is Laura Carstensen, and she is the psychologist who's been following people across the course of their lives. She has a cohort of some 300 people, from ages 18 to 94 when they started in her study, and she'd followed them all the way to the end of their life.

What was interesting to me was that as they got older, they became less healthy — no surprise — and they had some loss of function along the way. But they also had increasing sense of fulfillment in their life, despite all of that. And some other studies, that after age 65, people were more likely to have love in their life. They were less likely to have anxiety and depression. They were focused less on acquisition and having all the material stuff.

Ms. Tippett: This is another one of these great secrets, that growing old is actually a wonderful thing, and we're all about fighting aging.

Dr. Gawande: Right, and where it blew up my whole sense of what I was doing as a doctor is, I thought my priority was your health and your independence. And then that means that I was always lost. What is my goal for people when they're not healthy anymore or they don't get to be independent? What she opened up for me was the recognition that well-being was really about getting to what made those people happy, and when they lost that happiness is when they no longer were having some control over their own story, that they were not getting to be the shapers of their own story. That's what you see in people who are in hospitals or in many nursing homes, not all, where our goal is safety, survival, and health. And that's why you can gradually lose some functions and have some health issues along the way and yet have great satisfactions in life.

Ms. Tippett: Yeah, well-being. It's very concrete too. Enabling well-being is a very lofty idea. And then you talk about this woman who would have liked to have taken her grandkids to Disneyland, which is obviously a big undertaking, but so many of the stories you talk about are — you have these five questions to ask towards the end of life. And some of them are about your understanding of your illness, your fears and worries for the future, your goals and priorities, what outcomes are acceptable. But the fifth one, which seems to come through again and again, is, "What does a good day look like?" I think about Annie Dillard saying, "How we spend our days is how we spend our lives." And you tell so many stories about how just allowing those days to have the simple things that give people a sense of well-being, that that is everything.

Dr. Gawande: Yes, and this is the crucial question at any moment that people need help. On average, we will come to the end of life — we actually spend less time in dependency now than we used to, but we spend eight years, on average, in needing the help of others, over time. And answering those questions — I've found it's become my favorite dinner party question too — what is the quality of life that you would live for, if you couldn't do everything you wanted?

One person would say — my father said, for example, it's being at the family dinner table with family and friends and being able to enjoy some food and conversation and a connection that way. And then I wrote about the other person who said, "Well, if I can eat chocolate ice cream and watch football on television, that's good enough for me."

And then I met a health minister. We were in his office, and he had all these beautiful pictures of his family in the room, and I said, “What is the minimum quality of life? What is the good day for you? Is it being with your family?” And he said, “Well…no.” “It’s complicated.” He said, “You know, honestly, if I can just have a good book and some quiet, I would give up a lot to still be able to have that.” It tells you so much about people, and that’s the powerful thing.

Ms. Tippett: Well, it does, but it also points out, that’s so low-tech. The medical options are so complicated and expensive and sophisticated, and these are not unreachable goals, even for somebody who might be quite ill, to have a good book.

Dr. Gawande: Absolutely. And sometimes it does take that medical capability. I wrote about Peggy Batchelder, who was my daughter’s — when she was 13 — her piano teacher, who had a metastatic cancer and was laid up in the hospital for weeks on end. She just was miserable and angry and, ultimately, went home on hospice. And then the hospice nurse had that conversation: What does a good day look like? And then: Let’s have a goal, one good day.

And then they worked on that. At first it was, OK, we’re going to get you in a bed on the first floor, so you don’t climb the stairs. We’re going to arrange for getting dressed and bathed. And after two or three days of that, she lifted her sights. And then she wanted to teach piano again.

The idea that that was possible — it was extraordinary. My daughter had the most extraordinary piano lessons. And then there was a recital, and at the recital, they played Brahms and Chopin and Beethoven. It reshaped my daughter’s life, and that was the legacy Peggy wanted to leave.

My daughter just entered — two weeks ago, graduated from high school …

Ms. Tippett: Congratulations.

Dr. Gawande: And entered Berklee School of Music, because of Peggy. They were together only a couple years, but it made that impact. And that idea — that was beyond us.

Ms. Tippett: Oh, that’s beautiful.

Dr. Gawande: And that took real medical expertise too.

Ms. Tippett: Yeah, that collaboration. I know you’ve thought about this too, but you talked about growing up in Ohio. You said, “The experience of a modern old age was entirely outside my perception.” Because of changes in family, in society and mobility, we’re so segregated, we don’t have that experience, so I just think about your daughter, also, the experience that she had with her teacher and of someone dying, living while dying, and having a quality to it, seeing that that is actually a time of life that can have an amazing quality to it.

Dr. Gawande: Yeah, I was going to ask what you meant by the “quality.” What do you mean when you use the word “quality”?

Ms. Tippett: Well, a quality of life: that there's meaning and dignity — not just dignity, but real substance. It's not just somebody who is in bed dying, that they're living and doing things that matter to them.

Dr. Gawande: That's right, and it's finding your way through that, because there's plenty that also was not quality — that she would arrive, and Peggy had to work her way through some pain and work her way through some indignity, but then, also, find something really beautiful about that. Or, in another case, sometimes see the struggle for that and have real conversations we'd have at home about why is it so hard and painful, and reaching that place where you could see people in denial about the situation and not being able to talk about it. They'd see families where they wouldn't be able to talk about anything except "What's the next treatment we can try?" instead of saying, "All right, what is the next treatment we can try? But also, what's possible today? What can we do today that also makes sure we're not missing the chance to enjoy the time we have?" Those aren't opposed to each other. We start to see these conversations unfolding in multiple generations, and I think that's crucial.

Ms. Tippett: I think a lot about how some of the ways we grow more wise and sophisticated in our thinking are about innovation and some of them are about rediscovering something we forgot. So there's a way in which modern medicine is meeting a very old experience. You talk about your paternal grandfather in India. Way before people got sent away to nursing homes, people died surrounded by family and at home.

Dr. Gawande: Yeah, that complexity — I describe my grandfather's death. He got to live to 108 years in that village in Maharashtra, with family all around, and he spent the last 20 years of his life with infirmities that would've put him in a nursing home in the United States. But there, he was with family. He was at the head of the dinner table. People would come to him to bless their marriages, to get advice on business decisions — he was respected as the elder and could have that all the way to the very end. But it came at a cost. That was possible because the younger generation, especially the women in the younger generation, were more or less enslaved to his needs, his physical needs.

What India's going through right now is what we went through in the 19th century, which is — the shift from an agricultural economy was that young people got freedom. But I'm watching, and I wrote about the breakdown of the extended family in India as they advance economically and industrialize, because it involves people moving to cities and following their dreams. You get this complicated picture.

Ms. Tippett: Yeah, there's aging and dying, having a long life, and then there's — another thing you write a lot about is this modern tragedy of lives that are extended, kind of brutally, with all the best intentions and all the best aspirations and all of our best tools. I thought it was interesting that you note that when you have this process of asking patients about their priorities, you discover what they're living for — that often, that very same process ends up identifying the limits to the kind of care that people want, that that emerges in a humane and organic and very thoughtful way, in a way that it doesn't when medicine is just in this battle mode of "What's the next fight?"

Dr. Gawande: Yeah, this is really crucial, because what we often think is that putting your quality of life as a consideration means you're sacrificing quantity of life, because I'm thinking twice about whether to have that chemotherapy or undergo that operation. And the evidence is that it's not the case.

There are many kinds of studies. The most powerful one, for me, was the study that Jennifer Temel, a Massachusetts General Hospital physician, led, which took care of stage four lung cancer patients. They lived only, on average, 11 months. It's a terminal condition; no one lived past about three years. And what she did was, half of the group were randomized to get the usual oncology care, and the other half were randomized to get the usual oncology care plus a palliative care clinician, physician, to see them early in the course of their illness. It was sort of a radical idea — see them from the very beginning.

And the group who saw the palliative care clinicians from the very beginning did end up stopping their chemotherapy. They were 50 percent less likely to be on chemotherapy in their last three months of life. They were 90 percent less likely to be on the chemotherapy in their last two weeks of life. They were less likely to get surgery towards the end. They had one-third lower costs. They started hospice sooner. They spent more time out of the hospital. They were less likely to die in the hospital or die in the ICU. And the kicker was that they not only had overall less suffering, they lived 25 percent longer.

Ms. Tippett: Oh, my gosh. Wow.

Dr. Gawande: That's the thing we're missing out on.

Ms. Tippett: That's fascinating.

Dr. Gawande: It's like, if it were a cancer drug, if it were a pill, it would be this blockbuster company, and we'd all want stock in it, the whole thing. And then when I trace down, like, "What are you guys doing, and how can I do it next week without having to be you guys?" — the answer was, they were just having these conversations: Identify the priorities …

Ms. Tippett: It's just one person talking to another person, one human being and another human being.

Dr. Gawande: And activating the "My good day is 'X.' If I start feeling like my chemotherapy or my surgery is going to take that away from me, and that's not worth it to me, stop." And then they stop, and they feel better. And they do better for longer because the other thing it hooks up with is that we, as clinicians, are excessively optimistic about the power of what we're going to be able to do for you.

Ms. Tippett: Well, and physicians are authority figures. Physicians are some of the people in the world who we just hand over and believe that they know. You've said that we imagine that we can wait until the doctors tell us that there's nothing more they can do, but rarely is there nothing more that doctors can do. The scenario that you're describing, where there's this conversation and this participation, it's like it gives the patient or the person their agency back.

Dr. Gawande: This was what has been most transformative in my practice that I did not understand. What a clinician does, what we do with our authority has been a very tense issue over time. By the 1990s, when I was in medical school, we had rejected paternalism, rightly — "The doctor knows best; I'm just going to tell you what to do." We had replaced it with a belief in the patient's autonomy and a way of activating that. And the way of activating that was to give you options, to tell you, "Here is your condition. Here are the options: option A, option B, option C. Here are the pros, the cons, the risks, the benefits. Now what do you want to do?"

And then what I found in the real world — that was the way I was taught to exercise my authority, was to give people knowledge and then ask what they want to do with it. But what I found in the real world was that patients would ask back, "Well, what would you do?"

Ms. Tippett: What would you — yeah. Right, because you still know better. You still know better.

Dr. Gawande: Yeah, and so what we're taught to say so that you don't take away their agency was, "No, no, no. This is not for me to decide; this is for you to decide. Only you know you; I don't know you; and you have to make the call here around what's more important to you." And people felt completely abandoned. It never felt good.

What the palliative care clinicians, when I watched them — or geriatricians — would do is they would go one step farther. They would ask — not just tell you what your options are — they would listen, to ask, "What are your goals? What really matters to you?"

And that idea is that you are a genuine counselor. The only way you can offer wisdom is by connecting what you know and have observed about what happens with various things to the goals that this individual person has. The art of it is, can I extract, can I listen well enough, can I extract from this conversation enough to tell me what you really care about, to give you some guidance along the way here?

That is hard. I had to learn from the palliative care folks. One person said to me, "The family conversation is my procedure. It takes as many of those family conversations, learned with deliberate practice, to be great at it as it takes for you to learn to do your cancer operations. And so think of it that way."

Ms. Tippett: As I was reading the way you redefine, when you say about medicine, "We think our job is to ensure health and survival. But really it is to enable well-being" — I was thinking about — I was very honored this year to be invited to give the commencement address at the University of Minnesota Medical School. And I was so impressed with the pledge that the students of the class of 2017 had written when they started. And then I think they also give the students the opportunity to rewrite that at the end, but they actually kept the one they had. I wanted to read a little bit of it to you because I wondered, also, if you think there's a generational shift. I was really stunned. I'll just read it:

"In the presence of our families, colleagues, and communities, we take this oath in recognition of the honor and privilege of becoming a physician. We arrive at the threshold of our chosen

profession, pledging to preserve our humility, integrity, and all the values which brought us to the practice of medicine. We will engage in honest self-reflection, striving for excellence but acknowledging our limitations, and caring for ourselves as we care for others. We will seek to heal the whole person, rather than merely treat disease, committing to a partnership with our patients that empowers them and demonstrates empathy and respect. We will cure sometimes, treat often, and comfort always."

Dr. Gawande: That's great.

Ms. Tippett: Isn't that good?

Dr. Gawande: That last part, in particular.

Ms. Tippett: Isn't that amazing? And I have to say, it was the day of — there was all this drama going on in Congress about the health care bill and insurance. And it was so wonderful to be with them and see them and read this pledge they've taken that they wrote that's so very different from what I think a doctor of my generation would have written and to see — well, this is the future of medicine. This is it, this care.

Dr. Gawande: I think the place we are coming to is, when you take that pledge seriously, it becomes a really interesting dialogue, because people often are not sure about their goals, or they have contradictory goals. I, for example, will badger my patients about quitting smoking and wearing a seatbelt, but their actions are telling me they want to not wear the seatbelt or want to keep smoking. They're telling me what their priorities are. So if I'm an effective counselor, I might argue with you about your goals. And that role, as a clinician of all kinds, not just doctors, but it's nurses, psychologists, teachers, ministers — that is the deeper dialogue.

Ms. Tippett: Yeah, but that's the kind of arguing we do with people we love. That's also a form of care.

Dr. Gawande: That is when it is health care .

Ms. Tippett: Right — well, there you go. Did you know Sherwin Nuland, Shep Nuland? Did you know him personally?

Dr. Gawande: I did. Shep Nuland, surgeon at Yale, read his book, *How We Die*, which won — I think it was the 1980 or '82 or something, National Book Award winner, and it just blew the top off my head. That was the book that started me thinking hard about dying and what it means. I read it later — I was in medical school in the '90s, and I had no idea I would get to meet him and know him then. But when I started writing for *The New Yorker* and then wrote my first book, *Complications*, during my surgical residency, he wrote the review in *The New York Review of Books* and then reached out to me.

It was this great, very special relationship. We met only once, actually, face-to-face, but we weirdly enough, on *Talk of the Nation*, we ended up doing a regular thing, where he was the senior eminence, and I was but the junior pup doctor, and we would talk about a topic of the day,

every few months. It was now and again. But it became this dialogue that carried on. I was such a huge admirer. And someone who was navigating his own difficult paths — he had written about his deep depression and the conflicts he'd had in his life. And so he had a tough life and things he had to struggle through. So that was a very meaningful, influential relationship.

Ms. Tippett: I love thinking about that cross-generational conversation between the two of you. I interviewed him years and years and years ago, and the conversation I had with him was about some of the things he started thinking about later. We actually called the show "The Biology of the Spirit." And he was thinking a lot about our brains and about what spirit is, and — what did he say — that the human spirit is an accomplishment of the human brain? Just with this awe of — because he went on, after he talked about how we die, about how — the miracle of how much works all the time. *How We Live*— he wrote that follow-up.

Dr. Gawande: That was the follow-up book, yeah — which, of course, less people are interested in how we live.

Ms. Tippett: Yeah, less people were interested. And it was just full of wonder. I'm just thinking of that because I want to ask you about this, and I offered that as a way into this idea of spirit, whatever that is, if it is an accomplishment of our biology. But one of the things that I ended up talking with these medical students about was, I really do think — and I want your response — that 50 years from now, people will look back at the way we used to use this phrase, "mind, body, spirit" and think how primitive that was, because so much of what we're learning is about the distinction between these things — again, however you want to define "spirit," we know what we're talking about — but that what we call emotion and spirit are as physical as they are mental and that the brain lays physical pathways and takes bodily direction and that trauma and joy are in our bodies, as much as they're emotional.

I just wonder if you think about that, because it seems to me that even though — I don't know that I see you using that language very often — that this runs through your reflection: the wholeness of us, the mysterious fullness of us.

Dr. Gawande: Yeah, there's many ways in which I find the word "spirit" so difficult to understand. I use it all the time. For example, one of the ways I use it is just simply to ask people, after we're done talking about "How are you doing?" People then tell me about their aches and their pains and what their temperature has been doing and so on. And then I'll say, "How are your spirits?" Or "How is your spirit?"

That's one level, but then there's this interconnected level, the sense of spirit at a kind of — starts to become "spiritual," the ways in which there's some sense of something transcendent, at least across all of people, if not beyond that. I grapple with it a little bit towards the end of the book when I take my dad's ashes to the Ganges, because again, I'm the apostate Hindu, the ultra scientist — and "What's the data?" But for him and my mother, it was that you bring your ashes to the Ganges in order to allow yourself to be released from the cycle of birth and rebirth and enter the state of nirvana, where it's kind of like a heaven, is the way I think about it.

But there was, for me, a sense of the spiritual connected to going there on the Ganges in one of those little boats and undergoing a ritual that has been going on for hundreds of years, more than a millennia, at least, probably a couple thousand years, and people coming and bringing the ashes of family members and chanting these same chants and being connected to this whole chain of generations, where there are things that my father completed that came from the generations before him; there are things that he was passing onto me and my sister that we are responsible for carrying on; and that there is something much larger than us that matters.

I end up calling it "loyalty" in the book. I wrote about Royce, a philosopher who was at Harvard in the late 19th century and wrote a book at the very beginning of the 20th century, called *The Philosophy of Loyalty*. And what it meant was that — he was arguing, we all have a deep need to live for something larger than ourselves. He went through a series of thought experiments to demonstrate it. One of them that really stuck with me was asking, "If I told you, half an hour after you die the world would blow up with everybody you know in it, would that matter to you?" For the vast majority of people, it would matter. And the reason why it matters to people is that it feels like it takes away — that the meaning of your life would be gone, that we're not all, at core, totally self-interested creatures, that we have things we live for that are larger.

Now, that's not the only piece of evidence. There's lots of others that he goes through and then others you can think about, along the way. But that, for me, is part of that idea. It's the closest thing I come to, to being able to recognize that idea of spirituality and connection and meaning that rises above your own life.

Ms. Tippett: Here's some very beautiful language in your book. I don't know if this was in the book. Anyway, you said this or wrote this somewhere, that "We are a link in a chain in making a contribution that goes well beyond our own life. And that's part of what makes dying tolerable. That's what makes being a mortal creature tolerable."

Dr. Gawande: Yes, a weird thought came to mind. I just finished, recently, this three-book series by a Chinese science fiction writer named Liu Cixin. It begins with a book called *The Three-Body Problem*.

Ms. Tippett: I tried to read those books, and I couldn't get into them. Did you love them?

Dr. Gawande: Did you really? You know what I'm talking about. Oh, my God — I totally fell into them.

Ms. Tippett: I love the title, *The Three-Body Problem*. I was really drawn to that.

Dr. Gawande: Right. The characters are unbelievably cardboard. They have no depth whatsoever. But it has this extraordinary scale of time, partly because, yes, the three-body problem is this other planetary system, which has three suns, and the planet is captured by the gravity of each of those suns. So every day, you're never sure when the sun is going to come up, what the temperature is going to be, whether it's going to be 300 degrees or minus-300 degrees, and how long the day will last — all those things — and will it be a habitable climate or not. And the creatures will dehydrate when it becomes terrible, and then, when water appears again, they

rehydrate and then continue civilization. It pushes the questions, because what he's imagining is the extinction of human beings but the continuance of other forms of life and how wide our imaginations go towards bringing those in and making them feel that they are part of our chain of being. Can we have a chain of being that goes on 15 billion years, that go beyond — Earth is extinguished, and humanity is extinguished, but we still feel there is spirit, in some way?

I don't know, it made me think of that, and I kind of believe in that. I found it really beautiful that it managed to expand my mind, to make me feel that I'm part of life and that even after human beings are gone, that there is meaning in our little contributions.

Ms. Tippett: Sometimes, you are called — I don't know if you refer to yourself this way — a "public health journalist," in addition to being a physician, obviously. I'm starting to think of you — I like this language of "citizen scientist." I kind of feel like "citizen physician" would be a good thing to call you. Do you like that?

Dr. Gawande: The word that I really liked, you used, was "citizen." What I'm partly trying to do is open the portal both ways, that the world of what happens to you in the course of our average, currently, 80-plus-year existence, is one where the people that are part of that relationship on the clinical side are also people themselves who are journeying through that pathway. I'm fumbling for this a little bit, but the sense that the portal that I hope I open is that I'm speaking not only as a physician to the outside world, but I'm also opening the outside world to us as physicians and nurses and others, to think of ourselves as just citizens and to break down that inside/outside and to make it all kind of seamless. It's a sensibility, more than anything I'm trying to make happen.

Ms. Tippett: Yeah, it's a porousness, though, too, and it's a conversation that you're curating, making possible.

Dr. Gawande: Yeah, and the sense of — I like getting down into the microscopic of the real stories of what happens when human beings care for one another and enter into these kinds of relationships, and you see everything that flows through there: money and jealousy and politics and misunderstanding and conversation, et cetera.

And then, furthermore, we're this interplay of knowledge and technology and trying to function in a world where none of us have a full handle on it all. We're inside a system, and we have to have some agency in that system. How do we not be powerless? And how do we shape that thing we're part of? I'm interested in not only the sense of inside and outside; I'm also interested in the sense of the microscopic to the telescopic and starting to arrive at a way that we feel connected, and we know the meaning and the feelings, as well as the data, about what's happening.

Ms. Tippett: Yes, and as you write about, this is a sphere of some of the most cathartic, existential, and potentially meaningful moments of being human, of our whole lives, take place in the context of health care. That's huge.

Dr. Gawande: That's why I feel like I have the unfair advantage of my fellow writers at *The New Yorker* . I live inside this material that is extraordinary every day, and I get to think about all these really confusing, interesting, sometimes distressing things, like, do we have a right to this

stuff called health care? Why are the costs so high? Or, why do we itch? What the heck is going on there?

Ms. Tippett: And how does investigating itching lead us to the question of consciousness itself? It's what you do.

Dr. Gawande: Right. Yeah, right.

Ms. Tippett: I want to say too, the question of what it means to be human, a big, ancient question, it actually runs — it's not just being mortal, but being human that runs all the way through your work. Here's some beautiful language from the epilogue of *Being Mortal*: "Being mortal is about the struggle to cope with the constraints of our biology, with the limits set by genes and cells and flesh and bone." The fact that we are limited is something that you come back to. I think you say, "To be human is to be limited." That has informed the way you have grappled with the definition and practice of medicine.

I'm curious about how this fact, this reality that to be human is to be limited, which is also so hard for us to take in, how that spills over into other aspects of the way you move through the world, how you move through the world as a human being.

Dr. Gawande: The first way that I think about it is — well, two things jump to mind. Number one, in my public health work, it's about the idea that we're all so incredibly limited, and yet there are ways that we string together and are almost unlimited as groups of people. It's the kind of magic of when that happens, when you all start pulling together and then you eradicate polio from the world, which we're almost on the verge of doing. It's just fricking amazing when you see that happen and how these limited, flawed — and to me, that was the amazement of surgery. We're these smart, great people, but we're all limited and yet can pull off these incredible, risky, complicated operations and forms of care that give people back their lives and give them many years of better life. So that's one, that's the first one that I went to.

And then the second direction — it's quite the opposite, which is that as I walk through the world, I'm constantly combating the fact that I feel the sense of coping with that limitation and being constantly aware of those limitations. One of my favorite *New Yorker* cartoons, which in many ways encapsulates me, is a gravestone that reads, "He kept his options open." And my way of navigating through limitation is trying, as much as possible, to keep my options open, try to navigate with as minimal risk as possible, which means you don't accomplish anything. So I'm always fighting that sense of needing to take the leap, despite the reality of imperfection, of mistakes, and push forward, make your bets. I have to make my bet without 100 percent of the information and certainty.

And that's, in many ways, to come full circle, the attraction to me about going into a field like surgery was very similar to the ones that drew me into the world of politics, which is that the best people I saw in surgery were like the best leaders, politicians I saw — who recognized that we're limited, that you don't have all the knowledge, that your abilities are imperfect, the information is incomplete, and yet, there are times when acting is the better choice than not to act. And then

you live with the consequences and learn from them, take ownership and responsibility, and move on. That sense of enacting that in our lives feels really important for me to aspire to.

The End