Fixing Healthcare Podcast Transcript

Interview with Marty Makary

Jeremy Corr: Hello, and welcome to the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of The Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong. His next book, Uncaring: How the Culture of Medicine Kills Doctors and Patients is currently available for preorder on Amazon or through his website RobertPearlMD.com. All profits go to Doctors Without Borders. Together we host the biweekly podcast Coronavirus: The Truth.

Robert Pearl: Hello everyone, and welcome to the eighth episode of season five. This season is focused on the culture of medicine and how it both supports doctors and nurses in providing superb medical care in the most difficult of circumstances, such as during the current coronavirus pandemic, but also leads them to inflict harm on themselves and their patients. If you want more information on the culture of healthcare, you can find links to articles and other podcasts on the subject on my website RobertPearlMD.com.

Jeremy Corr: Our guest today is Dr. Marty Makary. Marty practices surgical oncology and advanced laparoscopic surgery at Johns Hopkins and is a professor of Health Policy and Management at the Johns Hopkins School of Public Health. He has published over 250 scientific articles on the re-design of healthcare, medical innovation and medical treatment of vulnerable populations. He is also a New York Times bestselling author. His most recent book, The Price We Pay, will be released in paperback next month.

Robert Pearl: Hi Marty. This is season five of Fixing Healthcare. We've had amazing guests including Eric Topol, Zubin Damania (AKA ZDoggMD), Lena Wen, Lisa Sanders and Jen Gunter. As our final guest, I want to ask you about a variety of clashes between what doctors say and the actions they take. Are you ready?

Marty Makary: Let's do it, Robbie. Good to be with you.

Robert Pearl: Excellent. Let's start with something close to your heart. Doctor say, "We save a life at any cost." And yet we know that medical errors still take the lives of at least a 100,000 people annually, including my father. How do we explain the omissions that physician culture excuses and what should be done to improve our performance?

Marty Makary: Well, and you've been a great advocate for patients' safety given your story, Robbie, and I think, thank you for that and Jeremy good to be with you here as well. Look, I think we've got to recognize that we got to stop blaming individuals while at the same time talking about personal responsibility but this should not be a territorial battle. Look, we all go into medicine because there's a sense of compassion, there's a desire to contribute to something larger. And so, if we make it about bad doctors, we've really framed it in a way that's not very productive. And the reality is we've got good people working in a bad system. I try to be very honest about my own experience over prescribing opioids and I wrote about this in my book.

Marty Makary: It's that, I did it with good intentions, arguably bad science, the blame game goes around but ironically a year after we suggested that medical error was the third or fourth leading cause of death in the United States, it came out that it was really the number one cause of death among people under age 50 in the over prescribing of opioids. That was just one form of error and as you said, it's not just us tripping over a cord. Let's not make it sound like doctors are bumbling idiots and clumsy. Let's talk about patients falling through the cracks of our complicated system. Let's talk about us doing unnecessary things, prescribing things people don't need. We just went from 2.4 billion prescriptions 10 years ago to 5 billion last year, did disease really double in 10 years?

Marty Makary: We have a crisis of appropriateness, we have cracks in the system, we have good people doing things that sometimes we don't fully understand; the science isn't there. So, I think we've got to frame it differently and also just kind of stop the infighting. In academics we just want to talk about like, oh, what's the demographic characteristics of people who are dying? Is it 52% women and 48% men? Hmm! That's interesting. I mean, let's not miss the headline here and that is that we can do better and we need to define error more broadly not just things we do wrong as individuals.

Robert Pearl: Let me follow up what you said about the drug industry just as another example of where I see this conflict between what we think, what we say, and what we do. As physicians we often tell ourselves that we will go to events and expensive dinners sponsored by drug companies that they don't influence our prescribing habits. And yet, every study that's been done on the subject, has shown that they do. How can we help both physicians to recognize the pernicious harm that's caused, and help patients to understand that this reality?

Marty Makary: It's a good question. I don't know. I've thought about this a lot like I'm sure you have, and on one hand it's valuable for us to have good partnerships with industry. When I'm using a new device in the operating room, I would like somebody from that company that created it, the company that designed it, that decided where to put the buttons and the fact that you press a certain button twice to make it do a certain thing. I'd like appreciate having them in the operating room when I'm using it for the first time or I have a problem. But at the same time I don't want to be going out to steak dinners with them because then, there's kind of an unofficial expectation.

Marty Makary: Do you want to go to Cancun and get a free meal from somebody selling condos? No, you want to enjoy, you want freedom when you go down there. And I think there are these relationships that can be managed judiciously with good stewardship, and there are these relationships that go awry. And at minimum, I believe that why don't we just disclose them to patients.

Robert Pearl: In the book that I'll be publishing next month, Uncaring: How the Culture of Medicine Kills Doctors & Patients, I point out that there are both systemic and cultural issues at play but that the cultural ones are often unrecognized. You've been a leader pointing out how powerful evidence-based guidelines can be, how they lead to superior clinical outcomes, versus every doctor just using their own intuition and anecdotal experience and yet consistency in medical practice isn't the norm in physician culture or physician practice. In fact, it's often not even valued. Why is that? And what should we do?

Marty Makary: Well, clinical variation you've nailed it, is one of the greatest hindrances to improving quality. The 17-year lag from best practices to widespread adoption, really just intolerable to many of us. We all aspire to great quality and so when you see this, when you see the random haphazard and perverse drivers of variation, you really want to get angry. It's healthy to be angry at that. When you see somebody have a mastectomy that should be having a lumpectomy, you should be caring enough for that to be offensive. And the question is, do we just take it in and digest it as I saw modeled to me when I was a young resident and student, or do we do something?

Marty Makary: And I think too often we've created boundaries for good reasons to respect individual practice liberty, but we've basically created this cultural norm in the sociology of medicine of don't you ever dare cross those boundaries. And yet, most doctors will tell you that they know of a doctor who's doing stuff they shouldn't be doing.

Marty Makary: What are the channels that we have to address it? I mean, it's very difficult. Even sometimes the M&M conferences are review conferences of complications. You're going to criticize somebody that you need to share call with and that you work with and you have to deal with every day, it's very delicate and sometimes it's not done very well. How can we create a more open environment to talk about practice variation? And by the way, we got the insurance companies beating down us on you shouldn't do this, you should do that. Let's get away if we can for a second. Can I say something a little radical here?

Robert Pearl: Please do. This show is all about exposing listeners to all of the radical ideas and letting them judge them for themselves.

Marty Makary: Well, you know I like to push the field, and I do it with enormous respect for the people that I'm trying to push. How about we get the monkeys off our back as doctors? All this peer-to-peer, pre-authorization you can't do this on this, the all or nothing clinical pathways that disregard the fact that every patient is unique,

they're individuals with their own wishes and their own goals and their own unique circumstances, especially when they're older. How about we let doctors be doctors except practice variation but, do it within certain boundaries where we can look at the practice on an annual basis or on a six month basis and say that this practice pattern appears to be reasonable or this practice pattern appears to be a pattern of concern a yellow flag or this practice pattern exceeds a threshold that a broad consensus of experts believe to be indefensible, a C-section rate of 65% in low risk deliveries. That's an indefensible pattern.

Marty Makary: We're never going to have a randomized control trial. And I know you've done work on C-sections and reducing them, Robbie. So, I thought you'd appreciate this, should we have evidence to support that a C-section is 65%? Well, if we come up with these convoluted and archaic requirements which sound good, we're never going to get the randomized control trial, randomizing some doctors to a 65% C-section rate, and other doctors to a 21% C-section rate. That's an unethical trial. So, if we say we're only going to measure quality using evidence and evidence is defined in this narrow way, guess what? You're ignoring a lot of clinical wisdom, we are now using clinical wisdom to come up with practice patterns that are guardrails to say, "These are the doctors who are inliers, here are the doctors who are outliers." Most doctors do the right thing or always tried to. I firmly believe that and you probably agree, and the ones who are outliers, the ones who I don't call them bad, I call them doctors who need help. I was one of those with opioids. Most of us in surgery were.

Marty Makary: And so, that is an alternative to hounding doctors on every case and expensive and exhausting fight with pre-authorization, can we gold card the doctors who have appropriate practice patterns and spend our resources helping the doctors who are outliers or doing a deeper clinical review, that is what we're working on right now.

Robert Pearl: Let me dive a little bit deeper back into the physician culture. You're a surgeon, oncologic surgeon for GI problems, you have a lot of expertise in the area of a pancreatic cancer, and you understand that superior outcomes derive when individuals and teams perform higher volumes of specific procedures. When I was the CEO in Kaiser Permanente, I asked our 18 chiefs of OB-GYN and 16 of whom were women, how many laparoscopic hysterectomies a physician would have to do the previous year for them to be willing to have that surgeon operate on them? Not who would be, but how many? And they all said three to four a month, somewhere between 40 and 50 a year. You and I both know that the average OB-GYN physician in United States today, does fewer than 10. In the physician culture, dabbling is accepted, a little bit of everything is seen as being a balanced practice. How can we evolve what physicians do on behalf of patients to maximize procedural outcomes?

Marty Makary: Well, I think your success at Kaiser if I can attribute it to you because I really do think it was part of your leadership, is to say, "Look at a model where we're not going to create these perverse incentives where we're just going to pay you for the more you do." It's like asking a real estate agent, "Hey, can you show me

homes in a part of the city they know nothing about." Are they going to say, "Well, I'm going to refer you to my partner." It depends on their personal ethics, and it depends on how the incentives are aligned. And if they're not aligned properly, the real estate agent is going to go and wing it. We shouldn't be winging it in medicine. Now, there's exceptions, there's rural medicine, there's access issues, there's folks who are not going to travel, but we could do a lot better working as a team, if we stop seeing every individual physician's practice as a small business that is independent and competing with every other physician.

Marty Makary: And I think part of it is, let's be honest with people, let's encouraged second opinions if that's the way that people can get educated. We've done that research showing that the fewer hysterectomies you do laparoscopic, the more likely they are to be open. The more fewer hysterectomies you do period anyway, the more likely they are to be open. Well, what's best for the patient? And that I think has been missing from some of the conversations. So, if I could be king for a day, I would say, let's figure out how to re-align incentives in healthcare and promote more teamwork, which we do see in pockets of healthcare and when you see it, it's beautiful.

Robert Pearl: You went out on a limb, let me go on a limb a little bit. As physicians, we take an oath to first do no harm and yet the most recent data says that one fifth of patients who come to the ER in the United States or have surgery, received a surprise medical bill last year. Now, Congress has made a change, but then when the medical bill is not paid, these same patients of the doctors are often sued by the hospitals that employ the physicians, even when they simply can't afford to pay the surprise costs with which they were hit. And these actions are supported by the national organizations representing those physicians. How could we resolve the conflict between what doctors say and what they seem to do in clinical practice from an economic perspective?

Marty Makary: When you talk about corporate interests in healthcare, it gets daunting. But when you talk to the individuals working in healthcare, I've yet to find more than a handful of people that think it's reasonable to sue the socks off an everyday Walmart worker or food service worker who had insurance and couldn't afford to pay their bill. And the hospitals do this to garnish their paychecks, and it's a disgrace. It harms the precious public trust that we have that allows people to come to us to the emergency room, and we put a knife to their skin within seconds of meeting them, or they'll tell us secrets they wouldn't tell their spouse of 30 years within a second just because they're at the hospital and you're the doctor. That incredible heritage of taking care of anyone in need of that great public trust has been eroded by this horrible corporate practice of price gouging and predatory billing, and every healthcare professional in America should be offended by this disgusting practice.

Marty Makary: So, we've been bringing it to light as you mentioned, we revealed it in an article in JAMA, coming on a year and a half ago, and since then we took that data and many of the stories that my team documented on the restoringmedicine.org

website, and we showed the videos and capture the stories and one of my medical students who's a filmmaker put their videos up there and it was not the glamorous story that hospital CEOs sometimes say. "Oh, we work with anybody and we have payment plans and it's wonderful and we only sue as a last resort." Look, we found a hospital filed 25,000 cases in a community of less than 50,000 people and after that article came out and then I wrote about this in the book, The Price We Pay, we have a really exciting follow-up of all the data in the new paperback version that's coming out right now of the book, The Price We Pay. And in that follow up you'll see, we basically shut down this practice in most of the parts of the country where we saw it, especially in Virginia, where it was rampant.

Robert Pearl: So, Marty, you take care of very sick patients many of whom are in intensive care units, and as you know, in medicine we've made a huge stride forward over the past 20 years to the point now that we have the ability to keep people alive who will never get out of bed, feed themselves or control their bowels. Is there in your mind a point at which treatment becomes torture? And if so, how should that line be identified?

Marty Makary: It's tough. I see both extremes, I see both extremes. If you look at the appropriateness of care we've got two problems, over-treatment and under-treatment. But by far over treatment is dominating the problem right now. In the ICU, we have the problem of futile care, care that's entirely senseless and disrespectful and provides no dignity and it's painful for anyone to watch. Any reasonable person would know no one would want to be treated that way. We see that, and sometimes we're helpless with that because ultimately it's the family's decision. And on the flip side, sometimes we see people written off for dead when we feel like there's hope, there's a chance and it's reasonable going a little longer and trying everything a little longer, and then coming to making a decision. And so, we see both but by far right now I would say the dominant problem is futile care.

Marty Makary: And I think there's a balance there, but unless we start presenting things fairly and involving families, I don't think we can protocolize this, I don't know how. I mean, we've done a little bit of a good job with ethics committees that come in and provide a third party assessment. But, thank God for those people who serve on those committees, it's tough work, but how do we do this? We've got to start modeling good behavior as physicians to our young, to our students, student doctors, student nurses, student respiratory therapists. That is more powerful than any textbook. My students, they're amazing. They get it when it comes to the culture of medicine, how we're trying to push the field, how we're trying to quest challenge the status quo way of us doing things.

Marty Makary: They get it. They're total huge believers in relationship-based medicine and in shared decision making and all of this stuff. And they tell me, "Marty, you can't teach this in a class, It's useless because you know what, we're told we got to perform in these USMLE exams, and we know it's not testable, and when you put us up to it, we're going to study what we need to study to stay competitive."

And so a lecture is useless, 50 lectures is useless, You've got to model the behavior in the clinics.

Marty Makary: And so, we need to do a better job of that and we're trying, my colleague, Dr. John Cameron, maybe the most famous surgeon in the United States, wrote the textbook. He's known by former chair of surgery at Johns Hopkins, great friend, still a colleague. We have this thing where he's not operating right now but up to a couple of years ago, almost every week, sometimes every day, he would stop by my room and ask me for my opinion on something. And I would pop by his room and ask him for his opinion. Now, I know how he thinks. I mean, the guy's a giant. He doesn't need my opinion as a junior partner but he's modeling humility and that's what we're trying to do and unless we do that, I don't think we're going to see a lot of great behavior. So, we've got to do that in the ICU.

Robert Pearl: The last guest on our show, was a woman who has terminal metastatic breast cancer to her brain and to her lung, she's aware of the severity of the diagnosis. She's talked to nurses, she's talked to palliative care workers. She's actually never engaged with her physician around the question of end of life and death. I found that strange. I don't think physicians feel comfortable talking about death. To them, I think it's failure. How can we change this? And have physicians become more comfortable guiding patients? As you know from my book, when my dad was in his last days and we decided not to provide care, he never saw a physician again for two and a half days. And that bothered me as much as all the other medical issues around us. Is there something we can do to help physicians become more comfortable with the end of life, as well as the beginning of life?

Marty Makary: Gosh, there's so many factors. Society outside of the medical culture, society is sometimes creating this image that you're going to live forever. I mean, I was just with some family in Florida and they've got neighbors there and they said, "A lot of people here believe they're going to live forever, they think that they're in the fountain of youth." Life is wonderful there is probably just like in California, the weather is spectacular. They found out about a 101-year-old person who died and they made it sound like, "This is such a shock how could this happen? What happened? Like what went wrong?"

Marty Makary: Society is not dealing with the fact that none of us are going to be here forever, and we then get this outrage. We're breaking the bad news, I'll tell a family member, it looks like there's a cancer, it's pancreas cancer, it's inoperable and there's this anger and what I'm seeing is, society has misled people into thinking we're going to be here forever because they do not feel comfortable talking about death, they don't want to talk about death and instead they're angry at me. Like, "What are you saying, doctor? Are you saying they're just going to have to die? Like we're going to have to let them go?" Well, I didn't make these rules, okay? Life isn't fair, none of us get through it alive. And so, there are many of these factors, and I think we have to start being real.

Marty Makary: Now, we have biases too. You talked about the culture of medicine, our multidisciplinary cancer clinics increasingly are becoming sessions where we

look at scans and render recommendations. Well, what about how frail the patient is? What about what their goals are? What about whether or not they accept that they're at the end of their life and they're okay with it? It's very hard and, Robbie, you may relate to this, it's very hard to break bad news it takes a piece out of me, I used to do it a lot. Now, I'm doing more research so, I'm not doing it every day, but I'm not even great at it because it's an art form and what I've learned over time, is everybody wants to hear the bad news differently.

Marty Makary: And you think you figured out a good way to break it to people, and what I've learned now is I want to do a quick assessment to figure out, are they the sort of person that's like, "Doc, look, just shoot it to me straight, I'm fine with it, I know I'm in the chapter of life, I've achieved a lot of what I wanted to achieve. Thank you, doctor for letting me know and just shooting straight with me." And I realized, I'm more depressed than they are after I broke the bad news. And other folks, they want to know all the science. Other people don't want to know any of the science. Other people are distraught and others are okay with it. So, how do we again, model and teach how to talk about death appropriately?

Robert Pearl: Marty, you practice in Baltimore. So, you're very familiar with the statistics on the mortality rate for Black individuals from COVID 19, and that it was two to three times higher than for White patients. And if you ask doctors about it, they point to systemic issues, they'll describe how Black individuals often have jobs that require physical presence, they commute on buses and subways, they live in multi-generational households, and yet we know that when two patients came to the ER, early in the pandemic, when the testing kits were in very short supply, doctors tested White patients twice as often as black patients with similar symptoms. When they had a procedure done they gave 40% less pain medication. If they had a mastectomy they offered reconstruction far less often. If they did a hysterectomy in a premenopausal woman, they were more likely to take out the ovaries. How can we address the racism that exists in the physician culture in American medicine?

Marty Makary: Well, these are very real issues and I can tell you as somebody who looks different, you feel it, you see it and I'm not suggesting that I'm entitled to something different or should be treated differently because of it, but I'm just saying you see it out there and it's not fair and you see what other people go through. And so, the way we have addressed patient safety is we've talked about it a lot. And when you start talking about choosing wisely on rounds, and when you start talking about our national effort to try to address the appropriateness of care. And you start talking about the risk of a medication error when we're talking about a blood transfusion that somebody doesn't need. When you start having these conversations, the more conversations, the more grand rounds, the more papers that are discussed in journal club, the more the journals accept patient safety as a discipline, and now are allowing people to publish opinion pieces or confessions that they wrote for too many opioids in their career.

Marty Makary: When the more we fill our culture with open and honest conversations, the more we see the culture change. That's what happens in patient safety. We've seen it, you've seen it, you've led some of it, Robbie. And that's what we need to do with race. Racism is all around us and it's not necessarily diabolical, which is our classic understanding of it. It's implicit sometimes and it's unintentional and it's well-intended sometimes and people don't understand it. And the more we can talk about it from different points of view, the better. That's my opinion on it.

Marty Makary: You look at Germany, a country that, and this is all from the work of, I think his name is Bryan Stevenson who's written on this topic with race. He says, "Look at Germany and they have had a humility about their history. They have memorialized what's happened in a way that they remember it and they are reminded again never to go back to those days." And that's what he's trying to do now in his movement but I think there's value in having humility around these topics. When I came to Johns Hopkins, I think we had 60 cardiologists, not a single African-American. In a city that's like more than half African-American. I mean, how does somebody not think, "You know what, it's important for us to have some diversity with the least one." I mean, that's the unintentional, but implicit bias that we have not been talking about that we need to talk about.

Robert Pearl: There was an article out this week about the number of African-American editors in the journals and how minimally represented they are. So, it shouldn't surprise us that these types of topics are not ones that rise to the surface.

Marty Makary: Interesting. We actually started doing some of that research and I hadn't seen that that was published. I'm glad it's getting out there, it comes out of a frustration that we've had, that the journals have been largely controlled by a very small group of like-minded people and they tend to use cronyism to hire their editorial boards. You talk to the editor head, the chiefs, or the editors at some of these journals and their deputy editor and their editorial board is, "My roommate from med school and my fellow intern. I mean, this guy was my chief resident, I was his fellow." The value of diversity is to bring multiple points of view, sometimes points of view that challenge preexisting ideas. And when you see the group think with the COVID response, you see the value in having different points of view. I mean, we can talk more about that, but that's the value of diversity.

Robert Pearl: Marty, you and I are both specialists, but we both recognize that our nation has a shortage of primary care physicians. Assuming in the post-coronavirus era, that there to be greater downward pressure on healthcare costs due to the large federal budget deficits, the requirements of states to have balanced budgets, and the economic survival for small businesses that employ the majority of Americans. What can we do to undo the hierarchy of medicine and elevate primary care to the status and role that I believe, we both believe it should have?

Marty Makary: Well, Robbie, first of all I've done a lot of interviews and podcasts, and I must say, you have the best questions I've ever heard in my life. These are so well thought out. Now, primary care is slowly being elevated and the pay is going up making it attractive for multiple reasons to medical students right now because of the supply and demand curve. And the reason that's happening is that direct primary care is taking off. Medicare Advantage is valuing direct primary care and so you're having companies come along and set up practice and practice chains that are very profitable but they require primary care doctors to do great holistic care and navigation into specialists. And if you can do that well, if you can navigate to the doctor doing a reasonable C-section rate and not price gouging instead of the doctor at a 50% C-section rate and low-risk deliveries and overcharging for their services, that navigation is something that employers have never had a grip on.

Marty Makary: You can create narrow networks but it's tough, it's tough. If you can say, "Hey, your pregnancy test is positive," in a primary care clinic, "I'm going to recommend this doctor for you and that doctor is part of a high quality high value alliance or network." You've now revolutionized the entire healthcare landscape and you've created demand for high quality specialists who are fairly priced. The fundamental problem in healthcare is we have non-competitive markets. And when you do that navigation well, you've transformed it to a competitive market, even among our specialists. So, that's the exciting thing right now in primary care and that's why the salaries are going way up is that there's a shortage of these doctors to be that key prerequisite in that giant navigation plan.

Marty Makary: The plan is working. It has many names. Some are doing it well, some are still figuring it out, but it's direct primary care, it's globally capitated Medicare Advantage, it's the IORAs, ChenMeds, Landmark, Oak Streets. All of these groups they're popping up all over Amazon, Walmart everyone's getting into this business and it's making primary care attractive again in terms of a central place, in terms of how much money they bring in and I think that's a good trend right now.

Jeremy Corr: When it comes to very high profile physicians like yourself and even lesser profile ones, how do you intend to address the misinformation going around on social media as we've seen especially with the pandemic and recently the Johnson & Johnson vaccine with the FDA pulling it, how do you put these things in context or represent things to the public in a way where it's getting through the polarization, the spin, the click bait that they get from the news?

Marty Makary: Well, it's an ugly vortex that we all get sucked into and we've got to really resist it. And that is, to use the anonymity of social media to be less civil. And it's a really bad tone, it's not the spirit of healthy academic and scientific discussions about what should be best for people. Those are discussions we used to have. Now, everyone gets deeply entrenched. Like when we were supply constrained with the vaccine, we're basically rationing a life saving resource. I mean, that basically what we were doing in the United States with the COVID vaccine.

Marty Makary: Now, I don't like it, it'd be better if we weren't rationing, but you saw the old guard medical establishment incredibly uncomfortable, almost denying that we're rationing, insisting we stick to the rigid two dose regimen even though the first dose conferred a 92% efficacy in the New England Journal at four weeks and multiple studies have shown that and the entire UK experience where they reached herd immunity before we did, validated. And you had this old guard at the FDA and other officials digging into their position. And that's not how... we shouldn't act like politicians, we should have the humility to adjust our outlook based on the data as it comes in. If you're not willing to admit you're wrong and evolve your strategy, guess what? You wouldn't be wearing a mask during the pandemic.

Marty Makary: When I wrote the first piece calling for universal masking with the COVID pandemic in a major publication that was in the New York Times during the peak of that early spring surge, I mean, so many people were angry at me. And some on social media, so nasty, when I was warning of the pandemic in late February, along with Dr. Gottlieb and others early March and people were saying, "No, no, no, no, Dr. Fauci said this." And look, I love Dr. Fauci, I just reached out to him and told him I have enormous respect for him, but you know what? Sometimes you want to have more than one opinion at the discussion. And so, we've got to be civil. You see a lot of people now recognizing that they can be famous on social media and it's driven by clicks and anger.

Marty Makary: We shouldn't be an angry profession, we shouldn't be an angry industry, we're an industry where people are attracted to it because they want to be a part of something greater than themselves. They want to help. And so, I think we have to work hard to keep that tone.

Jeremy Corr: How do you plan on... because one of the things, I follow a lot of the #MedTwitter community and I see that community over the past few years since we've even started this podcast when the whole world got, when all of America got super politicized one way or the other, that community got politicized as well. I mean, I saw people blaming Donald Trump for every single death in America, and then other people blaming Nancy Pelosi and the Democrats for essentially all the economic damage and mental health issues and things like that. But when it comes to healthcare, science is science and how do you, I mean, it's great to be an activist, it's great to believe in things but how do you take the politicization out of that healthcare community when it's needed and say, "Okay, here's the science, we have a responsibility to share science with the patients and the patients not just their personal patients but the ones who look to them on Twitter for medical advice and see what they're saying, what they're sharing." But how do you kind of encourage your peers to do that in a way that takes that politicization out of it?

Marty Makary: Gosh, Jeremy I just love what you're saying. It's so true and that's what we need. And I think there's something to the forum, it's the medium that's in part driving some of this behavior because we're not an angry industry, we're not an angry people, we're not an angry nation. But when I see something that's a reaction

on Twitter, sometimes I get angry, I want to respond and it's like, "Whoa, whoa, whoa, this is an anonymous drive by shootings and stray bullets flying across social media is not a productive place to really have a conversation." People want to get into arguments and debate and yet if I'll ever have a face-to-face interaction with somebody that may have say written something nasty to someone else, or to myself, it's funny when I talk to them in person, they're always the nicest person in the world.

Marty Makary: You think somebody is a monster from their comments and then you talk to them and you realize, "Hey, no, it's the medium that really brought out the worst in people." And so, I just think you're spot on. I don't know what the answer is, I think we should be more civil, we should be above that, I go on Fox News a lot because I've chosen early on to accept the offer to go on that network and people always want to try to peg you. "Oh, is he one of us, or one of them?" Like as if everyone's dichotomous, like we are all one or the other. And the people who know I go on Fox News don't like me because they think I'm conservative and the people who go on Fox News, hear me talk about, "You got to wear masks and the hydroxychloroquine doesn't work and the governor of Texas shouldn't have had an anti-mask announcement." And they think, "Oh, he's not one of us."

Marty Makary: So, it's a lonely place, when you try to just talk truth to what you truly believe based on the best information and everyone thinks they're an expert right now. So, I gosh, I just love what you're saying, Jeremy. I hope we can get there, I hope we can be more civil. I don't know what it's going to take but I think it's important for all of us to see good leadership out there and for many of us to try to model what we think is appropriate behavior.

Jeremy Corr: I am a lay person myself, I kind of take the voice of the patient on this show and I think that's part of the chemistry Robbie and I have together as he takes it from the expert perspective, I take it from the perspective of the patient. And so, I know a lot of people in where I live, I live in a very blue community surrounded by very red rural Iowa. But that being said, I know a lot of people that have lost a lot of faith in the public health experts in the country. A lot of people on the right have kind of lost all the faith in Dr. Fauci, a lot of people on the left have kind of lost a lot of faith with how things have been communicated as well. What do you think can be done not just from the public health perspective and the leadership perspective, but to get patients and the average American to have faith in healthcare providers and the public health community and the news they're getting?

Marty Makary: Well, I have enormous respect for a lot of these folks, Dr. Fauci and many others, but I think it would help their credibility if they showed more humility and apologized for some of the big things they got wrong. I tried to do this myself in my recent book, The Price We Pay with all the opioids I prescribed. All my colleagues were doing it as well, it didn't make it right, I still feel bad about it. I mean, probably some people had fatal addiction from opioids that I gave

them, they should not have received. Now, I could justify it, but you know what? It's therapeutic to me at least to say, "I had it wrong."

Marty Makary: And it's probably good for people to see that humility. And so, where is that humility? And I think it would help if we made some actions or steps or words that spoke to, we told everybody to wash their hands like crazy, Jeremy, we should have told them to mask up. We saw the Asian doctors urge us to mask up, we blew them off. We wanted to see the data, we should have just listened and looked at their experience with SARS in the past. We should have known that SARS-CoV-2 which is COVID, behaves and is transmitted like SARS-CoV-1 in the sense that it's micro droplet aerosolized particles.

Marty Makary: We should have made that connection, we didn't. When we told people to stay at home, we should have told them to get outside socially distance. That humility, I think would go a long way in restoring the credibility, which has been damaged by the mixed messaging and the many different things that have come out. The CDC has been mostly wrong or correct and very late on a lot of the big issues and I think humility is one of those things that you can't read about in a textbook and teach, but it's something we can model and we need more of it.

Jeremy Corr: And I think to that point, the biggest thing I'm hearing a lot of frustration about is, when we think of how the regular person understands vaccines, I think the biggest frustration I'm hearing now is the messaging that even after you're fully vaccinated, you still need to wear two masks and socially distance and I think a lot of people are like, "I've waited this long I've been in the pandemic this long, why the heck I'm I vaccinated? Can I please just go back to normal life? Why the heck do I still need to wear double masks and social distance? This is ridiculous."

Marty Makary: Right. Well, I mean I can just tell you as a doc, you've got to give people something to look forward to and create incentives when you want them to make sacrifices. So, we want people to get vaccinated, I think it helps to let them know that a month later you're going to be liberated. And as you know, I wrote the piece in the Wall Street Journal that said, "Hey, look, let's make the messaging very simple: Get your vaccine, wait a month for that immunity to kick in to a reasonable level and then live a normal life." Now, in the interim, we're asking people to continue to wear masks in indoor, public settings, even if they've been vaccinated, because business leaders just say, "it's too hard to enforce a partial masking policy."

Marty Makary: So, let's respect that, but why does everything in America have to be one extreme or the other? Why do you have to be all pro universal, double masking after vaccination or no masking whatsoever; masks are BS. Why is it that we have such a hard time, being in this lonely place in the middle where you're actually just intellectually following what you believe to be the best science and what's reasonable.

Robert Pearl: Two last questions. First, if you could change only two or three things about the physician culture, what would they be?

Marty Makary: Primarily change the incentives, it's the way you can align incentives will allow you to pit friends against each other or create the dream team of teamwork. And that is something we have not been talking about. Now, if you're sitting at the top of the pile, letting everyone fight and creating the hunger games can be more profitable, but ultimately it's a penny wise and pound foolish because teamwork really drives excellence and ultimately I think it can also increase the durability of a profitable system. We don't see that the incentives are all messed up, they're all messed up and we have pockets of success and you've been a part of some of them, but I would change the incentives number one. Number two, I would get rid of all the useless, can I say "shit" on this show?

Robert Pearl: Sure.

Marty Makary: All the useless shit we teach our medical students and pre-med students and residents and fellows, all the 16 years of education that I went through learning stuff that has nothing to do with patient care that you don't need to memorize. And it came at the exclusion of so many other things that are important to know, like how to break bad news, and burn people out at the prime of their life. We do that all the time to our young, it's disgusting what we're doing. Making every medical student memorize the Krebs Cycle at six different points in their education, for what? I mean, we get the most creative, bright, altruistic, athletic, amazing young minds in the history of the world. They're coming through right now, they've incredible backgrounds, they're motivated, they're driven, they come in, they're the cream of the crop and we take these people and we beat them with this useless crap, memorizing the intermediaries of the urea cycle.

Marty Makary: Why are we telling them to memorize that stuff? How about we explain to them how it works and show them how to look it up? And if they end up becoming a urologist, they can go into a deeper dive. We beat people down with so much useless memorization. The model is so flawed and it's because the AAMC insists on rote memorization as a litmus test of how good of a doctor you are. We're not bringing the right qualities into medicine using that prehistoric model. And I think that's the other thing I would change besides changing the incentives in healthcare.

Robert Pearl: So, finally, if you could preserve and magnify one aspect of the physician culture, what would that be?

Marty Makary: Look, we have an incredible heritage. And if we can prevent greed from setting in, sometimes you hear about these great ideas that entrepreneurs have. Doctors say, "Hey, we can deliver diabetes cure differently." And it's all about the mission and it's great. And then overnight they sell everything to Optum. How about, let's not think about the exit strategy of your idea. Instead, let's think about the goal of putting people first, of the selfless heritage of the medical profession. I mean, there were doctors at Johns Hopkins, if somebody came in from out of town to see them, they would pay personally out of their pocket for their train ticket. And this was at a time when the doctors weren't

making a lot of money. They would never charge a member of the clergy or the police force or the fire department or teachers.

Marty Makary: When Salk invented the polio vaccine, he refused to get a patent on it despite all his friends urging him to get a patent. Look where we are today. And, look I believe in markets but how about that incredible heritage in medicine to do whatever possible to help the most number of people. I think we don't model that, we don't see a lot, it's instead something when we see it, we revere it and we're inspired by it. I think we need to take those stories and put them at center stage because they're alive and well in healthcare today.

Marty Makary: There's a revolution, gosh, look at the Chen family in Florida, those clinics are all over the country now. They're changing lives. They're loving people. They're inspiring people. They're attracting doctors who want to provide holistic care and not just throw insulin at people with diabetes. They want to give them cooking classes and they want to treat back pain with ice and physical therapy as often as they recommend surgery and opioids. And they want to address sleep and stress when they talk about high blood pressure not just throw anti-hypertensives. And they want to talk about environmental exposures that cause cancer not just chemo. They value life, they create communities, they address loneliness. That is what's attracting our best and brightest and that to me, represents everything holy and sacred about our wonderful profession and that's what we need to put center stage as we carve a path forward.

Robert Pearl: So, beautifully stated, in my book Uncaring, I talk about my experience with physicians who volunteer to go around the world to provide care often working 12, 14, 16 hours a day without air conditioning, eating rice and beans. Or I talk about a physician who went to Liberia and while he was caring for patients with Ebola, he had to have IVs going into him because in the 120 degree weather, he was sweating so much. He would have passed out from dehydration. And every person I've ever seen who's come back from this mission and purpose global trip has been so happy, so satisfied. It's so opposite to what exists in American medicine today.

Robert Pearl: Thanks, Marty, for being on the show today and for educating the audience on the complexities of the physician culture and the challenges our nation faces going forward. Your expertise is vast, and you have provided a wealth of valuable information for listeners to consider.

Jeremy Corr: Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you liked the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook, and Twitter @FixingHCPodcast.

Robert Pear: We hope you enjoyed this podcast and will tell your friends and colleagues about it. If you want more information on these topics, you can visit my website: RobertPearlMD.com. Together, we can make American healthcare, once again, the best in the world.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.