Fixing Healthcare Podcast Transcript

Interview with Marty Makary

Jeremy Corr: Hello and welcome to the new Fixing Healthcare Podcast, Breaking The Rules. I'm one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO at Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of The Permanente Medical 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 healthcare—And Why We're Usually Wrong and Uncaring: How the Culture of Medicine and Uncaring: How the Culture of Medicine Kills Doctors and Patients.

Jeremy Corr: All profits go to Doctors Without Borders. If you want information on a broad range of healthcare topics, you can visit his website at Robertpearlmd.com. Our guest today is Dr. Marty Makary, a nationally renowned surgeon, professor, author and medical commentator. His most recent book, The Price We Pay, describes how business leaders can lower healthcare costs and explores opportunities to restore medicine to its noble mission.

Robert Pearl: Hi Marty, this is the third episode of season seven of Fixing Healthcare. Our focus is on breaking the rules of healthcare. Its premise is that small changes won't be enough to address the many challenges of American healthcare. The problems are just getting worse too rapidly. The focus is on the unwritten rules, the ones we learn in medical school and residency, not in lecture halls or textbooks, but that we master by observing how attending physicians and chief residents act. As you know, often we're not aware of what they are. But when the vast majority of physicians behave in the same way, there must be a rule that everyone understands and follows.

Robert Pearl: So, let me ask you, what do you think are the four or five most broken parts of the American healthcare system and the care that physicians provide. And after you identify them, let's delve deep into each.

Marty Makary: Okay, sounds good Robbie, great to see you again. Thank you for having me and it's always a pleasure talking with you, especially given your expertise and experience and all your books that I've enjoyed. I would say that the big areas that we don't talk about that we need to talk about are the appropriateness of care which is now getting some traction in the world of so-called precision medicine, or the inverse addressing low value care. Another is the cost crisis, and it's something that we've got to pay attention to. Another is the concentration of power in academic medicine. It lives among a few individuals who control the editorial dates of journals, and that's not healthy for any open scientific dialogue.

Marty Makary: Another is care coordination. We still have people fall through the cracks, and we have people who not only die from the illnesses that bring them into care, but they die from the care itself. That's something that we still can do much better on. And finally, how we educate and train our young professionals. We have focused on rote memorization so heavily that we've almost lost track of humility, self-awareness, and basic skills of human connection, what we call the non-technical skills of life. It's those skills that make a difference, not just our technical skills.

Robert Pearl: That sounds like a great agenda. Let's start with the appropriateness of care. What do you see as being an outdated rule in this area, and how would you change it? How would you break it, or would you replace it with? What are your thoughts about what we need to do differently going forward?

Marty Makary: Well, this is a really exciting area in medicine right now. I call it the appropriateness of care. It goes by many names just like if you will holistic medicine goes by many names, functional medicine and none of them truly capture the spirit of what a holistic approach to patients is. And same with appropriateness of care, no one term, be it addressing low-value care or improving precision medicine truly captures what we're talking about, but let me describe it to you.

Marty Makary: If there's one theme in the medical literature in the last seven or eight years, if you had to string together every publication and identify one common thread, that thread would be that indications that we thought were broad are far more narrow than we previously recognized, and that the group of patients that benefit from our interventions are a subset of the larger group in which we are applying those interventions. Now, that's good news. It means that we're getting better and it also means that at the same time, we've got have our eyes open and pull back on some of the things that we've been doing. For example, when I was in medical school, we decided to recommend one medication for every single living adult human being in the world every day.

Marty Makary: We decided as a medical community that every single human being should take a medicine once a day, and that medicine was aspirin. Well, it wasn't really that straightforward. It turns out that surgeons were talking about GI bleeds they were seeing people from aspirin that were sometimes fatal. Neurologists were describing hemorrhagic stroke and it turns out that in the final analysis, the number of individuals harmed from aspirin exceeded those saved from the reduction in heart disease among low-risk adults. The U.S. Preventive Services Task Force is now pulling back that really reversing what was a colossal recommendation into one that again is highly selective for precise audience.

Marty Makary: Now, we're seeing that in every area of medicine, in my own field of surgery. We're seeing appendectomy now applied to a subset of those who have appendicitis, instead of everybody. Antibiotic treatment isn't a more accepted first line therapy now supported by three RCTs. This is the appropriateness of care. This is where we can now talk about how can we do better and be more

precise. When we talk about drug prices in the United States, we can talk about PBMs and the middleman and the waste and the gouging, and all of those topics that I love talking about. I've described in the book, The Price We Pay. It talks about our cost crisis as a business of medicine 101 approach.

Marty Makary: But let's be honest, the best way to reduce drug prices is to stop taking medications we don't need. Medication prescriptions have doubled over the last 10 years. These are the areas where we can do better.

Robert Pearl: Marty, do you see a role for artificial intelligence in helping physicians to understand the particular procedure, whether it's indicated for an individual patient or not?

Marty Makary: Well, you must live in Northern California, because that's a common idea that floats in the Silicon Valley circles and I know you're on the cutting edge of things and yes, the answer is yes. I think there's a big role, but I often joke around with our own hospital administration when they banner the idea of allowing AI to help us do something. I remind them we don't need AI right now, we just need I. We just need some basic common sense. We have not figured out some of our most basic processes.

Robert Pearl: So, let me push one level deeper then. As you point out, physicians often don't do the approaches, provide the care that evidence-based literature indicates. How do we change that in a way to ensure that every patient gets the right care, the best care each time?

Marty Makary: Well, I think it's probably the most challenging problem we have in all of medicine, and that is how do you advance best practices? And at the same time, allow people to have the individual liberty to custom tailor treatments for their individual patients, all of whom are different and at the same time, do new things, try new innovations, and push the field to study different ways of approaching things. This is the ultimate challenge in medicine, because we're not doing very well. We've got a 17-year lag time between best practices being widely adopted from when they are first described in the literature with solid evidence. What we are trying to do through our work is to try to show doctors where they stand around what we call high value practice patterns, relative to their peers.

Marty Makary: In other words, show them where they stand on the bell curve. Traditionally, what we've done in medicine is something that's not very healthy. That is we just show utilization data back to doctors, or we show them organizational level complications like infection rates for an entire center or unit. When you show data on an aggregate basis, people don't feel that it's them. They don't change their behavior. As a result, what we're doing is we're really feeding organization level back to organizations and that data is not actionable. If I show an individual where they stand on the bell curve when it comes to their individual rate of performing something that they should be performing frequently, then you see tremendous improvement immediately, an auto correction.

Marty Makary: Nobody gets punished, there's no high-powered consultants that are enrolled in. This is basic data feedback, and it's something that we're finding is very powerful. It's been called dear doctor letters. It's been called internal data transparency, and so that is a very exciting area in medicine right now. And I think it does help advance best practices and reduce low value care.

Robert Pearl: Let's dive into the second area you spoke about, which is the cost crisis and we could spend a huge amount of time, and you have in prior Fixing Healthcare episodes, describe issues around exorbitant drug pricing, hospitals that consolidate simply to raise the dollars they can charge insurers and so in the systemic realm, but what do you see within the care delivery process that contributes to the cost crisis? What are the rules we need to break to change it going forward?

Marty Makary: Well, I think the cost crisis in healthcare having spent a lot of time on this topic is really a function of three factors. One is pricing failures in the marketplace that enable price gouging, and they also enable the second factor which is a giant growth of a middleman industry. This is a group of thousands of millionaires that we've created who are not patient facing, who are not contributing to patient outcomes. They're simply processing things, repricing claims, and managing pharmacy benefits for employers. This is a massive industry. As a matter of fact when United Healthcare was reported in their quarterly earnings on Wall Street to have a 25% growth in revenue from the prior year, they were asked why such a big jump in one year.

Marty Makary: How do you make that much more money in healthcare in one year? Things are not changing that much. This is pre-COVID, the year pre-COVID, and they responded by saying it was because of their pharmacy benefit manager company. They own a pharmacy benefit manager. So, you're seeing this tremendous growth in the middleman industry. We as physicians are in the best position to fix that, because we could go direct, we can bypass it. And finally, the third biggest driver of our cost crisis is care coordination. Now, care coordination is such a mess because we've only decided to incentivize doing things and not incentivize the overall coordination of care. This is mostly a failure of the payment system not a failure in the morals or altruism of the people we attract in medicine.

Robert Pearl: Let's talk a little bit more about the cost crisis and the idea of the physician being able to bypass the middle manager. If we look at an area, let's just take what's called biosimilars, very expensive drugs, the 10 most expensive drugs in the United States. Sometimes, there's no alternative besides the patent-controlled medication with a very, very high price tag, but often there are alternative drugs that at least in the research laboratory and the research clinical experience have been shown to be equally effective and yet, physicians often will prescribe the drug that has the brand name on the prescription pad the rep gave them, rather than the far less expensive agent.

Robert Pearl: Justifying it by saying the patient's out of pocket will be identical, but of course, the total cost contribution to the American healthcare system is exceedingly difficult. How do you see this problem, and how do we break that rule that it's okay to prescribe a more expensive drug before you've tried a less expensive, equally efficacious one?

Marty Makary: Well, I think first of all, we don't know the price of most of the things that we're prescribing. Now that's starting to change, especially in oncology. Again, internal data transparency where we can show somebody how much of one bone sparing agent versus the other that they're prescribing as an oncologist, because the second one was approved in a non-inferiority study wasn't better, but because it's more recently FDA approved, there's a tremendous buzz that this is the hot new thing, and this is what you should be prescribing. Well, it's tons more expensive. We are now saying, "Hey, we want to show you how much you're prescribing drug A versus drug B when we know they're equivalent," and that should be a part of how we practice medicine.

Marty Makary: It should be a factor. We should be able to know these prices. Financial toxicity is a medical complication, and billing quality is medical quality. These are things that are measurable, but up till now, we've only been measuring infection rates and readmission rates. We've got to start measuring billing quality performance and the price of services.

Robert Pearl: Like you, I am very concerned about the cost of medical care because I think it's leading people in many cases to not get the medical care that they need and desire, because they simply can't afford the out-of-pocket expenditure. They can't afford even the coverage in many, many cases. And when I speak about this at meetings, invariably the first person with the microphone asking me a question points out how much money we spend at end of life, how it's often exceedingly futile and asks what should we do about it. So, let me point that question to you. How do you see end of life? What are the rules that we were trained in? Should they change and if so, how?

Marty Makary: It's interesting because the area of end of life is a big opportunity to reduce unnecessary healthcare costs. However, it is the most difficult out of all the areas of financial waste to reign in and here's what I mean by it. I can point and show you in detail areas of waste and healthcare where anybody, doesn't matter what political party they have allegiance to, will agree that it's egregious, it's corrupt, it should stop, and it is wrong. Now, there's a lot of those things in healthcare actually. There's a lot of area where there's broad consensus, but reining in inappropriate care at the end of life is one of the most challenging, because it is still and always will be an art form.

Marty Makary: It's not something that can be managed with policies or rules. It always needs to be sensitive to the individual goals of the patient, the family, the wishes, the realistic nature of pulling through, the what's the gray line of futility versus heroic measures, how long do you persist for? Look, I have a lot of experience with this in the ICU, patients that may have a very advanced cancer and also, in

the short term separate from that very advanced cancer are struggling in a way that, if they get through, may give them a couple more months, maybe several months before that stage four cancer then statistically is likely to take their life.

Marty Makary: At what point do you say, "Look, they really want to try to live for those several more months"? If we do everything here for another day or two, we might be able to deliver on that, but after a day or two, let's reevaluate and maybe at that point, we've crossed over into futile care. These are very difficult decisions. I've had people tell me that a patient is we should stop doing everything, and I've thought no, this patient can really get through this. The way I see it, these are correctable problems in the ICU and it's at least worth trying a little more since the patient and their family are motivated. And the patient gets through and they have a great outcome.

Marty Makary: And then on the flip side, I've had this delusion where I think maybe they can get through this and people tell me no, it's starting to border on futile care, and then the patient doesn't get through it. And I realized, "You know what, we went too far." So, these are very difficult decisions. I've seen both extremes, and the best thing we can do is have the conversations, teach our residents and trainees to make decisions with the nurses and the family members, get to know the patients before we care for them. When I evaluate somebody for surgery, I want to get to know them. I'm not just doing a procedure on an assembly line. I want to understand their goals or wishes.

Marty Makary: I give them different scenarios what the rate of recurrence is of the cancer, even if we successfully remove it and watch their expression, and see what they think. Some people come up to me and I give them the odds and they say, "You know doc, I've had a good life. Thank you for these options, but I think I'm okay without doing the surgery." That's okay, right? We don't have to convince them to do what our protocols slot them to do. And by the same token, we'll get some people who say, "Look, I want to swing for the fence and let's try to remove this cancer, even though it's got a 90% recurrence rate." And if you know they're a candidate and they're motivated, we're going to go to bat for them.

Robert Pearl: Let's move on to this issue of the concentration of power in academic medicine. This certainly ties into unwritten rules of medicine that date back centuries in Europe and early in American healthcare. I'm gathering that you think that they are outdated in the 21st century. How should they be changed?

Marty Makary: There was a time in the medical profession, where in order to get a medical degree in the English empire, you had to have a degree from Oxford or Cambridge, at a time when neither Oxford nor Cambridge offered pre-medical education. It was just a royal lineage, if you will. It was an oligarchy, and they had all of these rules and we still have these rules in American medicine. And many of them live in this so-called academic promotion process, and that is a major barrier in my opinion to scientific advancement. People playing the game to get promoted, and we see that a lot. What you have, not just with the

academic promotion process, but with the NIH hierarchy is this interest in small, incremental scientific descriptions and not big new ideas. The big new ideas, it turns out are very difficult to work on.

Marty Makary: They're high risk that the intervention may not work. They are expensive. They require a lot of buy-in from the senior researchers, who maybe vested in their own ideas in terms of the theory of why something should be done, or not done. Let's say you get take a very talented and bright young physician, fresh out of school. Maybe they have a lot of research background, maybe they have a research interest in something in particular, maybe they have an MD and a PhD. You take these highly creative people who are observing our medical sociology and the way we do things from a fresh standpoint, and they have a big idea. Well, they can't act on it, it's almost impossible.

Marty Makary: You've got to apply through a very clunky process at the NIH. It then goes to a study section of senior people, who all have their own ideas on how things should be done. And there's very little funding out there for them to do these kind of things. That's a broken process.

Jeremy Corr: Marty, when we talk about breaking the rules, one of the things that comes to mind is how outspoken you were during COVID. People like ZDogg, you, Vinay Prasad, the authors of the Great Barrington Declaration, et cetera were never scared to go against the grain. You're considered to be one of the top minds in healthcare in the country, yet I can't even count the number of times on Twitter I saw people with no healthcare background at all totally dismissing anything you said as misinformation, or dismissing your background saying that you had no idea what you were talking about. In science, I was always under the impression that the more credible ideas brought to the table, the better.

Jeremy Corr: Instead, "rule breakers" such as yourself, who went against the grain were criticized, censored, and silenced. Even when you said things that were later proven to be true, no one went back and apologized to you. And people are right now so quick to shut down anyone that goes against the grain. Can you talk about what is going on with this and how you feel about the current state of rule breakers even being able to speak their minds even when they're right?

Marty Makary: Well, first of all, this is a trend outside of medicine. This is a trend in society, and it's driven in part by big tech and people only following narratives that are affirming. And it's not healthy for society, but medicine should be different. We should really see this and not participate in that tribalism, and yet we do. What we saw was tremendous group think. I can't tell you when I was trying to warn people about the pandemic. A couple other doctors on this media circuit telling people, "Hey, we're going to lose hundreds of thousands of people, if not more." And that's exactly what I had said early on, and we've got to take this seriously.

Marty Makary: People would kept saying, "Well, the CDC website says this. Well, the NIH says this." Well, at some point, we got to think independently and this deferring to

the group think did a tremendous harm when it came to warning of the pandemic, surface transmission of COVID-19, the lack of funding for clinical research on COVID early on, the draconian hospital visitation policy that didn't allow people to say goodbye to their loved ones in person, a human rights violation, something every physician should have stood up against. Who are we to tell somebody they can't take the risk of getting a virus to hold the hand of their dying father? I mean that was inhumane, yet it was a group think thing. Every hospital fell in line.

Marty Makary: School closures, as you know, many of us spoke up very vocally against school closures of public schools. Here, we have kids who went to private schools who thrived throughout the pandemic, and kids who went to public schools who dealt with tremendous delays because of school closures. My niece, seven years old has really struggled because of the school closures. And then she finally is starting to catch up academically, and the school tells her she cannot come into school for a week because there might have been a close contact of an asymptomatic child. Well, she had COVID. She has natural immunity anyway. What are we doing? She tested negative, they don't care.

Marty Makary: The vaccine allocation we talked about, the decision paralysis we put states in and allowing for gaming of the system, because we didn't have a simple age-based allocation. We didn't focus on first doses as we should have. We could have saved more lives if you've got people dying in the ocean, why give people two life preservers when people are dying with none? The interval between the first two vaccine doses was too close together. That was with good intentions that it was designed like that, but we kept saying, "Look, the more you space out any vaccines of any kind, the lower the complications and the better the immune protection."

Marty Makary: Finally after two years of the pandemic, the CDC changed their guideline to recommend that and they said specifically to reduce the risk of serious adverse events, specifically myocarditis in young men. The cloth masks, boosters in young people, something that two top FDA officials left over in protest because there's never been any clinical outcomes data to support boosters in people under age 30. The undervaluing of therapeutics, not talking about things like fluvoxamine which has two RCTs in JAMA and Lancet, yet never talked about. The CDC withholding data, and ignoring natural immunity from prior infection. As you know, my Johns Hopkins team did a big study on the durability of that immunity, and it affirmed what we suspected and consistent with every other study done.

Marty Makary: Natural immunity is more protective against hospitalization than vaccinated immunity. Doesn't mean you should try to get the infection, let's drop the paternalism that we have in medicine, and let's just be honest with people about the data. We fired those nurses who had natural immunity. They had circulating antibodies, but we fired them from not getting vaccinated. Turns out when we did that, we fired the nurses least likely to spread the infection in the workplace.

Robert Pearl: You mentioned at the start about we need to change rules about educating and training medical students. I wrote a piece in my series on Breaking The Rules for Forbes where I spoke about the fact that as you said, memorization remains what we most value. We select people based upon their ability. The Step One exam was it's not become pass fail, but it was memorization of 10,000 arcane facts, most of which you'll never encounter or use, but that's how we tested memorization and it came from the 20th century when a 50-pound backpack would be needed to carry all the medical information. We now have a smartphone in everyone's pocket, and why are we training people on how to access information, how to apply it, how to communicate it, how to work with colleagues around it?

Robert Pearl: What are your thoughts? Clearly, you've also been surprised and distressed by how we continue to rely on a skill that has little application in the 21st century.

Marty Makary: Well, it's tragic because everything you say is correct, and yet the AAMC continues to inflict tremendous damage on a generation of young people, who are trying to learn how to be great doctors. They're forcing them to do all of this rote memorization, and it comes at the exclusion of other important skill sets. Because when you, and this is per the students that I know and talk to. Okay, this is direct from medical students. When you expect them to do a tremendous amount of rote memorization for big exams and then tell them, here are these other important topics, they're not really that testable like the importance of self-awareness, humility, how to run a meeting, communication skills, what we call the non-technical skills of being a great doctor.

Marty Makary: You cannot have a written multiple choice exam for those non-technical skills, yet those are as important, if not more important than the technical skills. The students are crying out. They're saying, "Look, we want to learn how to be great doctors. We want to learn the great bedside skill sets, but you're forcing us to memorize and regurgitate so much." Let's be honest, we got to focus and prioritize on something, and so we're going to de-prioritize all this other stuff and focus on the rote memorization. I'm told that David Skorton, who's head of the AAMC, that he gets it, but that he's just going very slowly in reforming some of this stuff.

Marty Makary: I don't know, I haven't spoken to him personally, but the AAMC has again too much power. It's the concentration of power in medicine, it's not healthy. And by the way, many of these organizations lack diversity. Look at the editorial board of the New England Journal of Medicine and JAMA, I think it was like one African-American out of 50 editors.

Robert Pearl: One last question, Marty. You and I are both aware of the data on primary care, adding primary care positions to the community increases life expectancy two and a half times more than adding 10 specialists, about the importance of prevention and the poor job we do in the United States, about the opportunities to reduce complications from chronic disease. The list goes on and yet in the medical profession, these activities are not given the status and the esteem that

the data would say it should. What's your view, and what are the rules that we need to break and replace going forward if we're going to be able as you say to make it a healthcare system, not simply a sick care system?

Marty Makary: Yeah, so I think it's a really good point you raise Robbie and unfortunately, what I just see is a lot of talk about racial and social disparities in healthcare and very little action. Now, my research team has basically taken the position this was a realization I had, I don't know, maybe 10 years ago when I realized I've gone as far as you can go in academic medicine. There's nowhere really up to go. I have no interest in being a dean and handing out diplomas on graduation day as much as I love students. And I don't want to be an administrator. I want to be a researcher. I realized there's nowhere else to go up.

Marty Makary: What are we doing just talking to ourselves at these conferences, going on panels and saying that it's important that we account for social disparities in health, but yet nothing happens. We're fooling ourselves, right? We're fooling ourselves. So, what I'd like to see is some real action, instead of words. Now I think in this entire area, there's a lot of very specific times when you'll see a complete reversal of principles. When the COVID vaccine suddenly became available, what you had was coming out of a very healthy discussion about racial inequality in America in the wake of George Floyd. The vaccine becomes available and immediately, people in healthcare exert their power to insert themselves in the vaccine line ahead of vulnerable Americans.

Marty Makary: Spouses of hospital administrators, 23-year-old esthetician in a dermatology clinic getting the vaccine first, hospital board members, friends of people who know someone on the hospital administration or leadership. What you have is this complete reversal of all the principles we just outlined that are important to racial equality. Then it happened again when testing became scarce, and we insisted that colleges should be able to test twice a week routinely, asymptomatic low-risk people, the lowest risk people on earth and yet, there was not enough tests to go around in the community where of course, we had vulnerable Americans who desperately needed to get tested when they did have symptoms, not just for asymptomatic screening.

Marty Makary: You may think well these are one-offs, but we continue to do this. This happens all the time in healthcare. It happens almost on a regular basis. We outline these important principles of social and racial equality within the medical profession and yet, we have these emergency situations that hit us where we revert back to the old ways of doing things. I think it's important for people to speak out. I'm still amazed that during COVID-19, the people who just decided to sit it out and not weigh in, all of the education psychologists, all the people who have committed their lives to studying the development of children. Schools closed for a year and kids covering their faces with cloth masks for almost two years and didn't say anything.

Marty Makary: Just said, "You know what, it seems like it is concerning. I'm just going to sit this out. I'm not going to say anything." What we have is this selective outrage

around these issues, and I think we just got to be more consistent and be more intellectually honest. Unfortunately right now, there's this sense of are you on my side? Are you on their side? What I call medical tribalism and it's done tremendous damage within the medical field. I think we need to speak out against it. We need to call it out when we see it and say, "Look, this is doing damage to our great profession, the idea that we're going to be somehow tribal, the idea that somehow we're going to invite those to discuss an issue who have like-minded views."

Robert Pearl: Marty, thank you so much. You've pointed out many rules, several of which I hadn't even thought about before today, but you're absolutely right. If we don't break those rules along with the other ones, we're never going to have the system we do want, and we'll never once again make American healthcare the best in the world.

Marty Makary: Thanks so much Robbie, good to be with you as always Robbie.

Jeremy Corr: Robbie, what do you think about what Marty said?

Robert Pearl: Jeremy, Marty is one of the most prescient physicians I know. His views on the many unwritten rules of healthcare are powerful. In so many ways, his conclusions align with what you and I have been discussing over the past few years, both on our Fixing Healthcare Podcast and on Coronavirus: The Truth. I concur with Marty that memorization is the foundation of medical education, that's an antiquated skill that when it comes to COVID, one size doesn't fit all and that the cost of healthcare is our nation's biggest challenge, with the solutions most likely to derive from data and medical science, not anecdotal personal perspectives. I can't wait for the next time Marty returns to Fixing Healthcare.

Jeremy Corr: I hope you enjoyed this podcast. Well, tell your friends and colleagues about it. Please follow Fixing Healthcare on Spotify, Apple podcast, your favorite podcast app. If you like the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com and follow us on LinkedIn, Facebook, and Twitter at fixinghcpodcast. Thank you for listening to Fixing Healthcare, Breaking The Rules with Dr. Robert Pearl and Jeremy Corr. Have a great day.