Episode 541: Just How Much Has Government Screwed Up Health Care? An ER Doctor Explains — and Tells Us How to Fix It

Guest: Dave McGuff

WOODS: I'm so pleased to be able to talk to you and get the physician's angle of your book, *The Primal Prescription*. I was just telling people about it reminding them of my discussion with Bob Murphy, your coauthor, who does the economics of it. But he told me, he said this Doug McGuff, he knows all the economics too, so he's the ideal doctor.

MCGUFF: That's true. I'm a bit of an economics geek. Actually, one of my attendings when I was in residency who I dedicate in front of the book, William Allen, actually got me started in that. My graduation present when I got out of residency from him was *Human Action* by Ludwig von Mises, and it took me a solid year and a half to read it, but I read every page of it. I've also been through George Reisman's book on capitalism, along with the study guide and everything in between.

WOODS: All right, so okay, you know the stuff.

MCGUFF: Well, you know, nothing like what Bob does or you do, but I tell you, it is an amazing lens to look at the dysfunction of medicine through. I think — and I've really got to thank Dr. Allen for this is without that lens to be able to understand what fundamentally has gone wrong in medicine I think I may have just gone insane. Without being able to have some sort of grasp as to why things have gone so bad, I really would not have known how to react to everything that's happened in my career.

WOODS: Are you familiar with the — I feel silly even asking — but the American Association of Physicians and Surgeons?

MCGUFF: I am, and I am a member.

WOODS: Okay, I think it may be Association of American — I always get it wrong. So okay, they're good; they're great; they're a free market alternative to the AMA.

MCGUFF: Yes.

WOODS: I want to ask you about one model that you propose for how somebody ought to look for a doctor and the role the doctor ought to play. You use the concept of the sherpa.

MCGUFF: Yes.

WOODS: And after you describe that concept, you say — and now I'm quoting directly from the book: "Political and financial forces in medicine have made it almost impossible for a doctor to operate this way." So first tell us what you mean by a doctor as sherpa, and then I want to know what are the specific things that have happened that have made it impossible practically for a doctor to do this for you.

MCGUFF: Yes, well classically if you look even into the Hippocratic Oath, the doctor is the servant of the patient, and if you have a correct financial relationship with your physician, you can have that correct relationship. You've got to remember the golden rule, and that is, "He who holds the gold makes the rules." Currently under this very distorted third-party payer system — and indirectly, this governmental payer system that we have — the physician is being paid by this third-party payer, and as much as 85% of the time, a government payer. So his care that he provides to patients, number one, the type of care that is encouraged and even mandated is based on providing care to a population, to a collective, not to an individual, and secondly, is protocolized, meaning that there are certain rote things that they expect you to do for certain patients in certain situations, and if you deviate from that, then there is either non-payment or financial penalty for that deviation. So the physician under the current medical system is very much painted into what the government and third-party payers are trying to protocolize what's best care.

WOODS: So what should I ideally look for in a doctor? Let's suppose there weren't third-party payment; let's suppose there weren't government involvement — or let's suppose there were, but I could somehow evade it. What is the ideal that I want?

MCGUFF: Well, the ideal is to find — you need to actually interview our physicians, as you would anyone else that you were going to enter into a business relationship with. And you want someone that is going to understand your perspective of how you want to be cared for should something untoward happen to you. And you want them to seek your input as to what your care would be. And sometimes the knowledge required to do that can be extensive, and at times you're going to have to simply put your trust in them, but you always want to do so from the standpoint that you're the boss, and this is very much the sherpa relationship I describe.

The sherpa is a person that's acclimated to altitude, has grown up in that area, and knows the mountain that you're going to be climbing with great intimacy. They really have superior knowledge. But they are there serving you. They're working for you, and they're serving as your guide, but you are the boss. But if you're a good boss, you will really seek their guidance and follow it to the greatest extent possible, but always with the understanding that if you disagree or if you want to take another tack, then

you are still the person in charge, because the correct financial relationship between the two of you, between buyer and seller is evident there.

And I think that's what you need to try to seek out in your personal physician. You need to find someone that is going to help you navigate the medical system as it currently exists. This is treacherous territory, and you want someone that shares you philosophy, both economic and life philosophy and healthcare philosophy, but also is going to be able to help you navigate through this regulatory jungle that you're going to have to go through should you need to seek medical care.

WOODS: How well can I approximate the model that you're describing if I avail myself of one of these concierge practices where I pay cash directly, I don't go through a third party, and I don't use the government?

MCGUFF: It depends on the nature of the particular practice. There are concierge practices that are available on a primary care basis, but they don't do any hospital work at all. Ideally, you would want to participate in a cash practice or a concierge practice that also has an inpatient care component to it, but that's not always possible, not only from the standpoint of the physician not wanting to be involved in the hospital side of medicine, but sometimes being overtly disqualified from participating in the hospital side of medicine.

So if that's the case, you at least want someone that is able to care for you when you are sick, and if you're sick enough to require hospitalization, they need to have a mechanism set up whereby that they can communicate closely with the inpatient physicians. Most inpatient medicine now is practiced by hospitalists, which are generally internal medicine or primary care specialists who focus on inpatient care, and these are excellent physicians by and large who practice very good medicine, but by the very nature that they practice inpatient medicine they're under incredible pressure in terms of regulatory burden and practice parameters that they have to follow.

But if they have the appropriate input as to what the patient wants, that can be — I don't want to use the word subverted, but your wishes in terms of you care can be taken into account in a way that doesn't make you victim to a protocol that you don't want to be part of. And I think if you have a primary care provider that has a good working relationship with a hospitalist service in the area where he practices and is able to keep in close contact should you be hospitalized, I think that is probably the next best option for you.

WOODS: Now, let's say you can't find anything at all like this near you. There's still some advice that you can give people about — for example, you have a section on how to choose a doctor, how to choose your primary care doctor, and you give practical advice, like for instance, it's your opinion that women should not use their OB/GYNs as their primary care doctors. What kind of advice can you give us along those lines?

MCGUFF: Yeah, and when I say that I don't want to upset any particular group of physicians, but I really want people to establish a relationship with a physician with the idea that you want to have this relationship ready to go should something happen that lands you in the hospital. And in general, that means you want someone that practices a fairly broad scope of medicine, and for most adults that's going to mean an internal medicine specialist or a family practice specialist, because if you get admitted to the hospital and you're having pneumonia, for instance, or a cardiac issue that came unexpectedly and you're a female and your physician is an OB/GYN, they're not going to be well versed in that area of medicine and they're not going to be the person to take care of you. And even then, if they have to communicate with the person that is, their ability to guide the person caring for you in a way that respects your philosophy and your wishes is going to be somewhat compromised. So I always say select that kind of physician.

And also, make sure when you establish your primary care provider, that it's someone that is actually practicing in the care of sick and injured people. There are a lot of people that are trying to escape this dystopian medical system that we have by going out and practicing integrated medicine or wellness medicine, which is a valid market, but it's not going to be very useful for when you actually get sick, unless that person has a dedicated segment of their practice to illness and injury. So I would just make certain that you have someone that is well trained in a breadth of medicine, either internal medicine or family practice, and that they actually have a significant focus of their practice not just on wellness, but on taking care of you when you're sick.

WOODS: I want to shift to Medicare because of statement you make in the book. I'm going to again quote: "Medicare is the most onerous of the third-party payers and has served as the template for everything bad in commercial insurance." Can you elaborate on that?

MCGUFF: How much time do you have (laughing)?

WOODS: (laughing) Yeah.

MCGUFF: Here's the thing, and this is what's always bothered me about medicine, is that for whatever reason, the areas where we need a free market and a money-priced system the greatest seem to be the areas where we are least likely to have it. And you always hear when the arguments come up about government-run medicine or socialized medicine or single-payer, the argument always springs up — you know, you always see it pop up on the Internet that, you know, one's health and one's healthcare is too important to trust to the free market.

And the real issue is it's too important not to trust to the free market, because the amazing thing that the price system does is — how can I put it? I mean, there's an objective world out there. There's a real world out there, and we need some sort of signals from that real world to make important decisions with, and that's what the money price system does. And the amazing thing is it works throughout all of reality, including medicine, such that if there's an active price system in a complex endeavor

such as medicine, a person that has to engage in that complex endeavor doesn't need to have all the requisite knowledge of being a physician in order to make a good decision. That's what the price system does. You don't have to be an expert to get the best deal and to have affordable care or an affordable commodity. That's the great thing about the price system.

I am a technology idiot. My 12-year-old runs my computer life for me. But I can go in to the Verizon store, buy my cellphone plan, and they'll give me the cellphone. It's affordable to me, and I don't have to know how to code computers or put together a cellphone in order to buy the best quality device. But people are always so afraid that if you allow the free market that somehow the fact that you suddenly need medical care would be exploited against you, ignoring the fact that if you tried to do that, a myriad of competitors would come in an negate that.

Well, Medicare is basically socialized medicine for those that are 65 and older. It is the antithesis of that. And the reason that free markets and capitalism are so easy to pick on is what the price system is it takes the mistakes of the market and puts them out there for everyone to see. And what socialist markets do is they take all their mistakes and try to hide them and sweep them under the rug and put them somewhere else. And every time they make a mistake, rather than correcting that mistake, they double down on it, and they actually apply more of what caused the problem instead of less of it.

So in essence, Medicare is the prototype for all of these mistakes swept under the rug and trying to be covered up, and the single distortions that occur because of that amplify over time, and that just bleeds out into other third-party payer systems. But Medicare is just the penultimate of a third-party payer system and everything that goes wrong with it, if that makes any sense, and if you want to talk more and try to dry off particulars we can, but in essence, it's just that signal distorting attempt to hide your mistakes that is really what defines government-run healthcare.

WOODS: Then the response would be, as you well know, a lot of the care that people need, especially as they get older, is very, very expensive, and if they didn't have Medicare, for all its flaws, for all its awkwardness and difficulties, it's there and it supplements their own cash payments and makes it possible for them to get the care that they need, and that that is the key thing, that yeah, maybe we can reform some of the problems with Medicare, but the fact is it's there, and if it weren't there, people would really be suffering.

MCGUFF: Yeah, but the problem with that argument is it ignores why is medicine so expensive. If you look at any area of your life where you have something that is of extremely high technology but very affordable, even such that the least affluent elements of our society can have it, you will find that in free and unfettered markets, because prices always drop and the supply of available goods always expands when markets are free and prices are allowed to signal. The reason prices are so expensive in medicine is because of the signal distortions that are created by a system that won't

allow prices to express themselves and won't therefore allow the mistakes of the system to be exposed to the consumer.

And what also is ignored is most people think that this argument about government involvement in medicine began in 2012 with the Affordable Care Act, but it really — and the book does a very good job of demonstrating this — is it really began way before that. It began in earnest in the 1930s with the development of Blue Cross Blue Shield. So what resulted in prices being so exorbitant so that everyone became fearful and rather than enacting the cure to the problem they became fearful and that fear was exploited to create these gigantic government-run systems of care actually began way back in the 1930s and has been incrementally going on for a long, long time.

WOODS: I would be curious to get some stories from you. You've been in emergency medicine for 20 years; there must be anecdotes; there must be things that happened to you or things that confirmed your views. You have a lot in the book that only a doctor who has years of experience would know about, but can you share in particular anything anecdotal from your own experiences that has made you say everything I believe is clearly correct, because I'm surrounded by perverse decisions, perverse structures, perverse institutional decisions and so on. What have you seen in your own work that would confirm all this?

MCGUFF: Sure, absolutely. I mean, emergency medicine, people think that even prior to the Affordable Care Act there was just no socialized medicine. Medicine has been socialized in this country for a long time, and in particular, emergency medicine, my specialty, has been for a very long time. And in particular, since 1986 and the passage of the EMTALA law, the Emergency Medicine Treatment and Active Labor Act, which basically says that anyone that presents to an emergency department has to be seen, regardless of ability or even intention to pay for services.

So what that has done is allowed the emergency department to become the epicenter of every failed social engineering policy in our society, so it's kind of given me a front row seat to things, and it's also the pressure valve for the fact that coverage does not equal care. You can get insured; you can get put on the Medicaid rolls, but that doesn't mean that when you call a doctor's office that you're going to be seen.

What that sort of price control that occurs with that sort of subsidized care is that there's a long queue to be seen, and a lot of times you cannot be seen in any timely or meaningful fashion, so everything flows towards the emergency department. So you have problems of massive emergency department overcrowding. And if you go to any emergency department in this country and just walk in there any time of day, you'll find every bed full, as many hall beds as there are real beds, and that many more patients waiting out in the waiting room all the time, because the supply and demand is so distorted by the fact that we're not allowing prices to express themselves.

But to give you, just for one instance, when they talked about the passage of the Affordable Care Act and everyone was all up in arms about death panels, as if there was going to be a panel of six or eight top-level healthcare czars that were going

to make decisions about who would get care and who wouldn't and how this would be denied.

And what I saw happen since 2012 is, one, there's always been price controls on the inpatient side of medicine. This is called diagnostic related groups, and basically for any given diagnosis you get a primary diagnosis when you're admitted to the hospital, which gives you a defined amount of time that the third parties will pay for hospitalization. So for anyone practicing inpatient care, there's this immense pressure once a patient is admitted to get them out of the hospital as quickly as possible so as to get the situation taken care of within the time constraints allowed by this price control.

The problem is that our country is full or very, very sick people with very complex medical issues, and it's almost impossible to turn anyone out in that short span of time. So even though I don't think it's a deliberate or a malicious intent, I think the pressures create a situation where a lot of people get discharged prematurely. As a consequence, those people bounce back. They show back up in the emergency room sick again and have to be readmitted to the hospital, and that was causing a lot of expense to the third-party payers.

And what CMS, Center for Medicare and Medicaid Services, did starting in 2012 was to enact a financial penalty for readmissions to the hospital within 30 days. And the way they sold this to the public was we're going to make them take better care of you when you're in the hospital so you won't bounce back. We're going to put pressure on the front end so you don't bounce back on the other end. But that's really not how it works. People were still bouncing back in 30 days, only now hospitals were under immense pressure, because they had people bouncing back that they were now not going to get paid for or even financially penalized for.

So lo and behold, all sorts of alternative dispositions were found for these patients that were discharged before completely well, got sicker, and bounced back. So now you find immense pressure through case managers, which are people that work in the hospital that try to find the most cost effective care for a patient, and someone that was previously readmitted to the hospital because they needed further care, now we find alternate dispositions for them. We find a home health worker to come to their house, we send them to a nursing home for rehabilitation, or even send the patient off to hospice.

And what I fear is happening here is that people that normally would have been readmitted to the hospital are not going off to venues of care that are less intense and where they may worsen in their condition or in fact die. So now these numbers are coming out saying, look, we decreased readmissions in 30 days; we're doing a better job. But what we don't know is the people that got farmed out to home health, to a nursing home, or to hospice, how many of those people died. So you see, with the correct financial pressures and incentives artificially introduced, you don't need a death panel. These people may — and I don't know this for a fact, but I have significant concern that by diverting these people away from readmission through

these financial incentives, you may be sending people off, and there may be significant mortality associated with that.

But like it is in all non-price-based systems, we're hiding those failures. The mortality that could occur by denying readmission in 30 days may be hidden. Those don't get counted in hospital mortality statistics if they don't die inside the hospital. So that's just one example of how these market distortions are actually played out to the public as an improvement in market efficiency, when in fact, it's exactly the opposite.

WOODS: Doug, I'm going to have to get you back on, because there's so much else I'd like to talk you about. You have chapters on "Getting off Your Meds," which is a really, really interesting and compelling and provocative chapter. You've got a chapter on "Surviving the Hospital"; I want to talk to you about mammograms and colonoscopies. There's still so much to talk about, so I do want to get you back, but before I let you go, as you look upon this product, *The Primal Prescription*, your book with Bob Murphy — and no doubt you've read other books on medicine and other books on free market medicine — when you look at this one, what do you say to yourself about what makes it different or why you're especially happy with it? What does it convey that hasn't really been conveyed in book form up to now?

MCGUFF: Yeah, I'm very happy with it, one, because in everything that's happened in my career in medicine I really haven't had a say. And here at least I get to have a say. But what's very unique about this book is, number one, it defends medicine from an economic standpoint, but it acknowledges — and I acknowledge this — that I know what checkmate looks like, and Obamacare when it came along, it was very easy to predict what was going to happen with it, and it's pretty much the opposite of everything that they said would happen with it. You wouldn't get to keep your doctor; premiums would go up, and they have, and they've gone up for everyone. The co-ops that they opened up to try to draw more people in to register are now folding across the country. It's the opposite of everything they said it would be. But what makes this book unique is it not only looks at what's wrong with the system and how it got that way, but how you can extract yourself from the system. Now, my job in the ER, I'm seeing people that are 30, 35 years complicit in the demise of their health, and I'm pulling them out at the last minute. So on one side of my career, here I'm being the lifeguard. But what my work in fitness and what my work in this book allow me to do is this is to teach you how to swim.

WOODS: Yeah, that's got to be very satisfying, that finally you've been able to do this.

MCGUFF: Yeah, and that's the neat thing about the book is this is how a good system could have happened, this is what really happened, this is what's coming, but you have power in this situation. You can prevent yourself from being drawn into the belly of the beast. You can extract yourself from the belly of the beast, and here's how. But even despite that, if by ill fortune or injury or accident you get pulled into the belly of the beast, here's a way to navigate through it to get the best that medicine has to offer, because despite all the economic distortions, there are elements of medical technology that are better than they've ever been. I mean, amazing things are going

on, and the physicians that are practicing now are better than they've ever been. And if you can navigate the system appropriately, you can get the best that it has to offer while avoiding the darker elements that are inherent in it.

WOODS: The book is *The Primal Prescription: Surviving the "Sick Care" Sinkhole*. We'll be linking to it on the show notes page, TomWoods.com/541, where we'll also link to the conversation I had with Bob Murphy, the other author, co-author of this book. And I've also given you a little shortcut directly to the Amazon page for the book; it's TomWoods.com/Prescription. It'll take you right there, and you can grab your copy. Doug, as I say, we've got to have you back on because there are so many other topics to discuss, but I want to give people time to digest this, and then we'll get into it again in the future. Thanks so much.

MCGUFF: Awesome, I sure appreciate the opportunity.