Episode 651: Austrian School Physician on What's Wrong with Health Care

Guest: Dr. Michel Accad

WOODS: You gave an interesting paper at the Austrian Economics Research Conference this year, so interesting that Jeff Deist, the president of the Mises Institute, devoted a whole episode of his Mises Weekends interview show to just playing the recording of your delivery of the paper. In fact, I tuned in expecting to hear an interview with you, and it was just you delivering the paper, so I thought, wow, Jeff must really think highly of this paper.

ACCAD: Thank you.

WOODS: So I wrote to you, and I said send me that paper, let's talk about it. So I do want to do that, and maybe we'll go off on some digressions, because I've seen that you've written on a number of health-related topics on Mises.org, so I feel like I can hit a lot of things and not worry that you're going to say this is not my area. It seems like everything's your area.

ACCAD: Right.

WOODS: Let's start with — I do want to talk about this theme of man as machine, but before we do that — I don't know if we can do this before we do that. What struck me most about your presentation was that when you ask professionals, you ask people even of different schools of thought, "What is health?" — what *is* health? What do we mean when we say that someone is healthy? It turns out that you don't really get a satisfactory answer.

ACCAD: That's exactly right. It's really the elephant in the room — I think I called it the elephant in the room in the talk — about health care, is that there's no accepted definition of health, and that's actually, it's not just me saying that. It's well recognized that there's no consensus on how to define it. It's a matter of debate, but the debates are not in the medical mainstream literature or in medical school or anything like that. It's sort of been confined to the philosophical journals that nobody reads, and the whole health care machinery goes on as if it isn't a problem.

WOODS: But it seems like it is *the* problem, isn't it?

ACCAD: I think so. I mean, that is essentially my thesis. My thesis is that the reason that we're in such a mess is because there is no good conception of health, or there is one or a couple, and they're faulty and they allow a lot of interventionism, essentially.

WOODS: Yeah, that's where I want to go. I want to talk about — what you've done in this paper is really amazing, I think. I didn't think what you did in this paper could be done, because every time I see somebody try to say, oh, this is a praxiological approach to such and such, it's a big flop and it makes no sense, right? But yours is really well done. So let's look at definitions of health that don't really work; then I want to look at your definition of health, and then bring in where necessary the idea that became current in medicine of treating the body as if it were like a machine.

ACCAD: Right, and one thing I would like to say here is that I hope when I say "my idea" or "my proposal," my intention is not to sort of fabricate an artificial concept of health, but on the contrary to try to restore what might be a natural meaning to it or a common sense meaning. And of course I use some praxiology or what not, but the idea is precisely that the health care system is founded on an artificial idea of health, and we need to go back to the original meaning of it, the natural meaning of it. And when you do that, then you can see that any form of interventionism is only going to lead to trouble.

So what I did, I tried to trace historical — you know, to go back to the ideas that have shaped the current health care system, the ideas about health. And we can actually do that specifically in the U.S., because here in this country, which is unique, there was a period of time, the mid 19th century, where health care was actually a complete free market business. And so what you had at that time, you had competing medical schools or schools or medicine — not medical school, but schools of medicine — competing notions about what health was. And they were not necessarily always explicit, but some of them were more explicit than others.

But there was one concept that emerged that was part of the movement within science that was sort of an ideological scientism, if you will, or ideological positivism that started to view the body, given the successes of the scientific methods, given the successes of physics and chemistry and what not, started really to conceptualize the body as a machine. And that had a lot of appeal to social progressives, who also wanted to manage society according to scientific principles and what not. So you had a marriage of these two movements that gave rise to the licensing laws and the licensing reforms of the beginning of the 20th century that essentially embedded into medical practice a certain view about the human body, a certain conception that was, yes, the body is a machine, that we need to train experts that are going to be essentially very technologically versed or scientifically versed to study the human body that way, and that will lead to great things.

And it's not that the model is completely wrong. There are certainly aspects of the human body that are like a machine, and it's very useful to think of the body in some ways as a machine, but it cannot be the be-all end-all of the human version, and if you

restrict your frame of mind or frame of thinking to the machine concept, then that's when the problems start to pile up over the years and over time.

WOODS: All right, so if it's wrong to think of the body as a machine, even if for some theoretical ways it can be helpful, how should be look at the body, then? If it's not a machine, then what is it? I mean, I guess it's tempting to think of it as a machine, because you think that, like a machine, it behaves in predictable ways, and that's why we can study it, because it behaves in predictable ways.

ACCAD: No, you're right —

WOODS: So then what makes it not a machine?

ACCAD: So what makes it not a machine is that, you know, we have minds and we are going places and we act and we have desires and preferences and so forth. I mean, that's one way we're not like machines. It's also important to understand how — if I may just spend a couple minutes on how the machine concept, how it went awry after the enactment of licensing laws.

WOODS: Yeah, yeah, do that. Yeah.

ACCAD: You know, because people don't realize that the licensing laws, the way they're very closely related to the accreditation of medical schools and the curriculum of medical schools. So the licensing essentially standardized the medical school curriculum into a way that essentially embraced this machine concept. So you don't think about health, but you learn about the machine. So you start with the components; you start with the building block sciences, you know, organic chemistry and biochemistry and anatomy and what not, and you build on that. It's like a constructivist approach, if you will, to the human body, without thinking too much about health or the good of the person or things of that nature. And of course, the machine model is fruitful from a therapeutic standpoint. You can find drugs; you can identify defects in the machine, and so forth, so it has value there.

But what it does, it doesn't allow for an understanding of health if that's all you limit yourself to, because to talk about health you have to bring in other considerations, as I mentioned. You know, what is the good of the person, what is the integrity of the person, and that sort of thing, which you cannot get with physics and chemistry, so to speak. And furthermore, what it does, it changes the culture so that the physician is viewed as the complete expert, and the patient is the subject — or the object, if you will. You have this situation where — and it was the case after the enactment of licensing laws. You have the rise of what's called medical paternalism, which was really pretty virulent in the first part of the 20th century, where doctors were really praised by the system and sort of elevated to the status of demigods and with knowledge of all this scientific power at their disposal and so forth, and patients were really treated very poorly.

And then it also give license to the medical community to medicalize all aspects of life, because there's no end — if you view the body as a machine, there's no end to the kinds of defects that you can identify or what not, and so you have this relentless temptation to just butt in to people's lives and tell them what's wrong with them and so forth. So I think it's a helpful model, the machine model, only if you restrict it to its proper place, which is to give you some ideas about the physiology and the structure of the effects of medication and so forth, but it cannot be the overriding model for health and for medical care for the medical encounter.

WOODS: All right, to help people understand this a bit better, let's imagine somebody, a patient comes into your office and is complaining about something wrong. How would you look at the question differently from how a doctor who believes in the machine model would look at it? Aren't you both looking at the same books and thinking in terms of the same symptoms and so on? How are you looking at it differently?

ACCAD: You know, we actually are probably thinking about it the same way, in that most doctors, just to make that clear, are good doctors and typically won't view the person as a machine. You know, we're all humans, and we instinctively treat people as human beings. But one thing that I wanted to sort of add, and I'm sorry if I didn't, to this machine concept, the machine concept, once it was essentially embedded into the licensing system, it gave the opportunity for third parties to start to insert themselves into the health care encounter, because remember that this machine concept defines the notion of disease as a defect in the machine and health as the absence of disease.

That's sort of the paradigm, the implicit paradigm if you adopt this machine concept. And so it views the work of doctors as purely technological and sort of an expertise in technology, so it's very tempting from then on for regulators to come in and supervise or subject health care to quality regulations and safety regulations, and you get a lot of oversight that sort of gets in between the doctor and the patient to try to control what doctors do and what patients do and so forth. And then you have the — additionally you have the concept that if the body is viewed as a machine — you know, this concept — and health is the absence of defects in the machine or diseases, then health care becomes an insurable event, so you have the idea that you can insure health care.

And I'm mentioning these, because they're really important, clearly very important aspects of how people practice medicine that have been around for decades now, really since the 1920s and '30s, and have always failed at what they're trying to do, trying to improve the medical system and the medical encounter. They've always failed, and you've had more and more regulations and more and more interventions, because it's all based on this very mechanical conception of health, of what health is.

Now, when people come to my office or they come to another doctor's office, we practice medicine, you know, if you we practice good medicine, we do it in spite of that entire burden of regulation and interference and what not that is there by virtue

of the prevalence of this mechanical concept of health, and we actually try to deal with patients as human beings. But the more the system interferes, the outside health care system interferes because it's been built on this misconception of health, the more difficult it becomes for doctors to take care of patients as human beings, to take into consideration what their preferences are, what their goals in life are, what their aspirations are, and to deal with them more humanely.

So it's not a very — what I'm saying is it's not like my conception of health is a revolutionary thing, but it's just a recognition that if you have a health care system that is built on this faulty machine concept, then it will in many ways screw up the way doctors and patients view each other and deal with one another. Does that make sense?

WOODS: It does. I'm thinking about the, I think it might have been the World Health Organization's definition of health, where health is more or less the absence of defects, and one of your points was that this would mean that a blind man could never be said to be in good health, even though if you asked blind people they would say I'm in perfectly good health.

ACCAD: Well, actually, let me clarify that. So when the machine concept was sort of adopted in many Western nations at the turn of the 19th century, the beginning of the 20th century, and sort of under this positivist, sort of scientific hopefulness that putting doctors as experts and viewing the body as a machine and what not would solve all our problems, and when that failed to materialize and in fact led to a lot of medical paternalism and abuse of power by the medical community, including the abuse of power that occurred in the 1920s and '30s under the eugenics movement, where people were really mistreated, there was a reaction to that after World War II, a reaction to this highly mechanical conception of health.

And one expression of that reaction was the World Health Organization said, no, no, this mechanical model is not sufficient; what we need to do is define health as well being, physical, social, and mental well being, not just the absence of disease or infirmity. And in a way that's an improvement, because it takes into consideration the subjectivity of the person, what people want and their well being and so forth. We're not supposed to view them as machine and so forth.

But on the other hand, it's also a faulty concept, because you can't just say that health is the — you can't equate health with well being. You would never be healthy if well being is your standard of health is. I don't know about you, but in the course of the day, there are many, many times when I don't feel perfectly well, and it does nothing to restrain the scope of medical care. In fact, it expands it, because if well being defines health, then there are all kinds of normal life situations that become fair game for the medical system to intervene.

WOODS: Okay, yeah, give me an example of that.

ACCAD: You know, Thomas Szasz, the psychiatrist, was very big about talking about the influence of the psychiatric interference, how everything has been medicalized, how psychiatry had invaded everyday life by having human beings seek out medical care or psychiatric care for problems that are not medical, per se. They can be maybe social problems or this — you know, now the tendency is to go to the doctor to find solutions to a huge number of problems, because we don't feel well, when in fact these are not necessarily or inherently medical problems or they're not inherently problems of health, if we were to understand health more properly.

And this sounds perhaps a little abstract, but I think most people recognize that there's just — you can't open a magazine now without having a medical doctor give you an opinion about something or other that used to be the realm of what your mother would be telling you about what to eat and that sort of thing and not having doctors interfere and intervene into every single aspect of our lives. Do you know what I'm saying here? From what we eat to how much we should exercise, you know, everything has become sort of a matter under the purview of the medical lens or the medical world.

And it's because, you know, in both ways, whether you talk about the mechanical concept of health or the well-being concept of health, both of them view the human person as sort of reacting to things, reacting to the environment, a victim, a victim of disease or illness, as opposed to viewing the human person as an acting person, as someone who's going through life making choices and going places and having a certain intentionality in what they're doing. None of that is present in the two concepts of health that I mentioned, in the two prevalent concepts of health, whether it's the machine concept of health or whether it's the well-being concept of health. It really ignores the fact that human beings are acting persons, and that's where I was inspired when I discovered praxiology and the philosophical underpinnings of economics —

WOODS: Yeah, do you mind if I jump in here, because I want to make sure — because we use the word "praxiology" like it's the word "butter," you know?

ACCAD: Right.

WOODS: I have to always remember that not everybody knows the word "praxiology." In fact, early on when I was on a date and I was told that the word "praxiology," that was a fake word. That word did not exist. So it does exist. There is a word "praxiology," and what we're talking about here is the methodological underpinnings of the Austrian school of economics, which is a frequent topic of the show.

And the basic idea of it is that it's a non-empirical approach to economics and the social sciences that builds on certain axioms, and the foundational one is the axiom that human beings act, by which they mean that human beings use the scarce means of this world in pursuit of their ends, and they have a ranking of these ends and they have preferences and so on. And from this basic idea, we can derive the concept of cost, of opportunity cost, of value scales, of diminishing marginal utility. A lot of economic concepts can be teased out of this basic insight.

So this basic insight that human beings pursue ends using scarce means, this is the insight that Dr. Accad is talking about. All right, so now we return to our regularly scheduled program here. You jump back in, and, now that we know what we're talking about, go ahead.

ACCAD: No, that's correct. So it essentially recognizes that human beings are intentional in the way they live their lives, and they're not like animals, sort of reflexive or instinctive, and they're not like rocks and chemical elements, just bobbing about according to the laws of physics. There's an intentionality to human action, which forms the basics of the economic science, Austrian economics.

And you're right in that humans act, and therefore they seek out external means to achieve their goals. But they also need internal means to achieve their goals, as well. They need to be in a certain physical condition, and they need to have certain mental capacities to achieve their natural goals, and this is where I thought it was helpful to start thinking about health in terms of having the internal means of action in a way that you're healthy when you have the physical and the mental condition to go about life to achieve your natural goals and your natural aspirations.

So I was getting inspired from the way economics has developed based on the axiom of human action. I was inspired to find this concept helpful, to identify a conception of health as being the state that occurs when you have the physical and mental capacity to go about and live your life. And disease occurs when there's something wrong either with your physical condition or your mental condition that interferes with your ability to go through life intentionally, the way human beings do. Does that make sense?

WOODS: It does. Now, I can understand how that definition of health is more intellectually satisfying, but in the actual lived experience of human beings, how could the widespread acceptance of that view of health have good consequences for us all around?

ACCAD: Right, so admittedly it's theoretical, and admittedly so long as medical education and the licensing laws and the entire system is not going to accept this model, I realize that I'm being theoretical. But nevertheless, I think it's important to have at least some conception of where we've gone wrong and where we might go right or correct the problem if we did so.

And the way it's helpful is because then the relationship between the doctor and the patient changes completely if you adopt this model, because now the doctor is no longer going to view himself or herself as an expert dealing with the subject. The doctor is going to view the patient as autonomous and as a human person acting who's having difficulty going through life and achieving their ends due to an impairment in their physical or mental condition. And the patient, therefore, is seeking out the doctor to help restore those internal means of action, their physical action and their mental condition, so the patient goes to the doctor to take over, essentially, those means of action and restore them to their natural state.

And therefore, I use the word "stewardship" or "steward" for what becomes the essence of medical care. The doctor then becomes a steward, because the patient is, due to the condition or the illness, helpless in taking care of themselves or moving forward, so they come to you and they put into your hands their physical condition, and it's your job to be a steward and to restore them to their proper condition.

So in a way, you have to adopt the point of view of the patient. You have to understand what their goals in life are to a certain extent. If somebody comes to you with an acute bronchitis, their goal in life is to get better immediately, so you don't need to know exactly where they want to be 15 years from now and so forth, but there may be situations where where they want to be in the future, in the long term, is important, so you need to take that into consideration. So if you as doctor view yourself as a steward, your approach is going to be very different from the approach you might have if you view yourself as the expert and you view the patient primarily as a subject or a machine that has a defect that you need to fix. Does that make sense?

WOODS: It does, and you know, I feel like I have to ask you this. It did come up briefly in your presentation, and I'm afraid, even though I have notes and I cross things out that I ask, I'm afraid I'm going to forget this one, and I want to ask you and every doctor that I have on; I want to ask this question. And as I say, it is indirectly related to what we've been talking about: the whole question of medical licensure. Now, here you are a successful physician, and yet your view is that the existence of medical licensing is an unjust imposition on the liberty of everybody concerned. And yet, the vast majority of the public would think that is a crazy opinion and that you are going to subject us to quacks, right?

ACCAD: Yes, yes, of course.

WOODS: So how can you justify yourself?

ACCAD: You know, it's easy. First of all, if you look at the historical record, medicine became a lot more dangerous after the enactment of licensing laws than it was. It's sort of, people let down their guard. They were told that the state had vetted all the doctors and that they would be safe, when in fact what it had done, it had empowered doctors and by then they had the scientific means to do a lot of harm, so they were a lot more harmful than the snake oil doctors of the old days.

And if you look at how medicine was before the enactment of licensing laws, it actually was getting better and better. And there's one paper that I wrote for Mises.org that looks at the Mayo Clinic, and the Mayo Clinic was born of the free market. So the finest medical institutions in this country, the Johns Hopkins, the Mayo Clinic, the Boston hospitals and what not were all born from the free market, and what was happening was they were actually putting the quacks out of business. The quacks were not surviving; they were disappearing, and you know, the licensing laws had nothing to do with medicine getting better or more scientific.

In fact, if anything it derailed things, because it forced this artificial concept of health that I mentioned, this machine concept. It forced it and made it sort of a quasi-reality, whereas before, doctors at the May Clinic and what not, they were using science, for sure. They were using science and technology because they were trying to help the patients, restore them to their natural health and their natural state. But they were not so mechanical or so callous as to view themselves as the experts who were granted now the privilege from the state to do whatever they wanted, essentially. So you can refute it. Now, I understand it's a tall order from a public relations standpoint to sort of make the case that medical licensing is not helpful, but I think it's a fact. I mean, it's undeniable if you look at the historical record.

WOODS: Then there is, of course, the fact that today, especially in the days of the Internet, anybody can check up on anybody. In two seconds you can find out everything you need to know. We're living in a world no one could have dreamed of back in the horse-and-buggy days, back when they thought that a medical license was what was necessary to save everybody. And of course it artificially restricts medical services, doesn't it?

ACCAD: True, it does; it does. It restricts medical services. And then the problem is with licensing, actually it clearly fails, even by the medical community's own standard. They keep saying, they keep imposing on doctors more and more requirements in terms of certification and licensing and continuing education, and there's no end to what they — how can a third party, a third person vouch for the integrity and the ethics of a doctor? They can't. All they can do is test their ability to answer a complicated multiple-choice exam, which most of the time has nothing to do with the actual taking care of patients.

And it restricts the pool of people who might get into health care and it makes health care more expensive. I trace the economic consequences of medical licensing in America, and it's one thing after the other. I mean, when medical licensing laws were enacted, it put out of business a whole bunch of medical schools that were deemed unscientific, and it really made access to health care a lot more difficult and a lot more expensive. Almost immediately after the enactment of licensing laws, there was a huge, the first crisis of medical cost inflation. So in the 1920s, everybody was worried about why medical care was so expensive all of a sudden, and they never traced it back to the licensing laws. And the response to that was to add more sort of interventions and to try to concoct health insurance schemes to try to answer that medical inflation problem.

So I don't want to take too much of your time on this particular subject, but you're right. I think medical licenses are the beginning of the health care system and they contain all the seeds of errors that subsequently unfolded over the decades.

WOODS: The paper that you gave at the conference, are you planning to get that published somewhere?

ACCAD: Yes, I certainly would. I'd like to have maybe two versions of it, one that would be more for the Austrian school folks, economists, because it's using the concepts of praxiology that I talked about, but I could also make a version easier for the medical community to follow that would — because most people intuitively understand, when I blog about these ideas, they're not really controversial. People recognize their value. Except that this entire history of our medical health care system and the history of our concepts of health, nobody talks about it. When you go to medical school, you never have once a class or a course or a discussion about what health is, and so I think it will appeal to some people to sort of try to put the two together or to try to recognize what we talked about at the beginning, this elephant in the room that our conceptions about health or our operational concepts of health are really faulty.

WOODS: And that's what surprised me the most. Not being a medical student, I had no idea what was taught or how it was taught or whether there was — I mean, I just assumed they could define what health was.

ACCAD: That's right.

WOODS: I took that for granted.

ACCAD: That's right.

WOODS: All right, well, listen, when either version is out, I want to make sure and link to it. I'll go back and retroactively link to it at TomWoods.com/651. So for now, just bear in mind there's a Dr. Accad-shaped hole in that show notes page, but it will be filled some day when it gets published. I appreciate your time and also your willingness to talk to me very much at the last minute, and thank you very much for that.

ACCAD: Thank you very much, Tom.