Primary Care Cures

Episode 70: Dr. Marty Makary

Rob Barshop:

Most problems in healthcare are fixed already. Primary care has already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buy outs, factory medicine, high deductible insurance that squeezes the docs and it's totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with host Ron Barshop, CEO of Beacon Clinics, that's me.

Today's guest is one of those folks that literally needs no introduction for this audience. Everybody knows who Marty Makary is, but before we get into talking with our guest, I want to talk a little bit more about the Marshall Plan. The Marshall Plan basically was 175 billion with a B dollars that were given to the hospitals from taxpayer funds we don't have to give to hospitals that don't really need them mostly. I've been into now 20 different financial statements of hospitals. We all know the names of them, well-recognized names in your community and across the country. And most all of them have at least a billion to $6 billion strategic funds that they use for different purposes, but probably to acquire referrals by buying practices and buying the whole referral network in the community around them, which it looks like buying independent physician practices that are orthopedics or primary care or OBGYN and that is how the referrals come into the hospital.

Well, they don't own 30%, but they will soon because this Marshall Plan did not rescue them from losses as much as it doubled their strategic funds. I was doing the math before the strategic funds were released. Now that they've been released, we know precisely what dollar amounts they're getting because we know how many Medicare patients they have. And we know 7,954 bucks is how much each hospital gets per Medicare patient they treated last year. And when you throw the Medicare advance on top of the Marshall Plan, they're getting billions of dollars. It's unconscionable in my worldview to be furloughing and letting people go like the hospitals are doing in large scale when they got a plan to basically keep all of them on staff paid for by the federal government at about a 20 X to 40 X of what their losses their reporting are.

Now, we know the losses are going to continue beyond three months of what we've been doing with, but all I have to say about this issue is hats off to the American Hospital Association, the most powerful and successful lobby in the history of the planet earth to pull off a Marshall Plan and have no transparency in return, to not have black box pricing eliminated in return, to not have ridiculous gouging prices in return, which our guest is going to be talking about today, eliminated, to not have reference based pricing. These are all things that we would normally get in a Marshall Plan. We got democracy for the free world and world peace last Marshall Plan. This Marshall Plan, we got nothing.

Looking forward to introducing you to Marty Makary. Dr. Makary is not only a surgeon with Johns Hopkins, but he's a public policy advisor and expert and teaches that. And he is

frequently in the White House trying to give clarity to folks that are trying to get the word out to the rest of us. Frankly and I'll tell you that I don't read a lot of the talking heads that are on television because I don't know that they have the clarity that Marty Makary has. His first book was called Unaccountable and it blew the lid off of the lack of transparency between who's paying and who's actually delivering services and why that maligned incentives is a big problem. His latest book, The Price We Pay, is the toast of the town for the last six months and it's not even relevant to that. We were just talking before the show.

Marty, super glad to have you on the show, looking forward to talking all this through with you.

Dr. Marty Makary:

Great to be with you.

Rob Barshop:

Great. Well, Marty, we were joking that before you wrote your book, it was an urgent and exciting project and after C-19, it almost looks like not only yesterday's news, but last decade's news doesn't it?

Dr. Marty Makary:

We're kind of redesigning the entire healthcare system in a matter of a few weeks here. It's an interesting time.

Rob Barshop:

What do you think primary care looks like when fee for service is essentially dead on the vine? What does the future of that going to be?

Dr. Marty Makary:

Well, I hope that primary care can finally have the acceleration it needs to actually take care of patients in a holistic, comprehensive way. The idea of coming in once a year for an annual checkup for 15 to 30 minutes and having followup visits of 7 to 10 minutes, so we can do our billing and coding is for the birds. The patients hate it. The doctors hate it. There's a lot of people making a ton of money in the so-called revenue cycle, billing, coding, throughput model world. And they're not bad people, it's just we've inherited a broken system that's getting magnified each year. Look, a young generation of doctors now, which I had the privilege of profiling in The Price We Pay are saying, "Hey, can we start talking about physical therapy and ice for back pain instead of simply incentivizing spine surgery and opioids? Can we talk about food as medicine? Can we talk about managing hypertension through better sleep? Can we talk about Alzheimer's prevention by addressing simple carbohydrate consumption and general inflammation?"

It's an exciting time right now and it's amazing. If you just let docs practice medicine the way they've always dreamed of, the way that medicine was designed to be practiced and then you add in some cool technology, It's a beautiful thing. It's just we've got to break through these shackles that we've inherited from a past generation.

Rob Barshop:

A future guest of ours is going to be Jeanne Teshler, CEO of a company called Wellsmith out of Austin. And what they've done with a Carolina company called [inaudible 00:06:19] Health you're familiar with is to reverse diabetes 30%. Now, other than lap band surgery and other than Virta Health, I've not seen anybody reverse diabetes, but they're doing it with an engaging application and wearable sensors that are ambient around the home at all times to give a massive data exhaust to help the physician have a better cue on what is going on in that person's life, in the 99.9% of the time they're not in front of their physician, as you said, because that's not scalable to have to go to a doctor to get advice all the time.

Dr. Marty Makary:

It's not. It's for the birds and somebody needs to tell us, "Hey, this is not working," at some point. We're on the treadmill and we're exhausted doing what we're told to do and we don't have time to stop and think. And if we just stop and say, "Hey, wait a minute. This entire model is not ideal. This entire model it's creating so much unnecessary work." And the solution is not what many doctors are told and that is work harder and that will allow you to make the margins that you need to have a better life. That is not the right.

And that this new generation of companies, like you mentioned, Wellsmith, Virta, which I love, Iora, ChenMed, you name it. They are what I call relationship-based models of care and relationship-based medicine is starting now to be triumvirate. It is starting to make a comeback and it is beautiful and we're seeing results that you could never imagine. 80% of patients have a reduction in insulin and about 30% of patients come off their insulin altogether among type 2 diabetics with Virta and some of these groups. Why? Because patients are hungry for a relationship with their clinician or clinician team and we are hungry to deliver that medicine because it's great care.

Rob Barshop:

I was on the phone with Gordon Chen yesterday for about an hour and they're looking to expand here in Houston, which is our base. And they have doubled their company size in the last three years and their panel's about 400 Medicare recipients, usually 65 year old, that's their market. They have a whole care team wrapped around them. They're reversing hypertension, all of the comorbidities that come with lifestyle diseases, who else besides the Ioras and the ChenMeds and the Virta Healths, who else is out there reversing hypertension, dealing successfully with mental, good gosh, the mental illness buildup is going to be enormous when this releases, but who else is reversing it out there that some you featured in your books and some maybe you've discovered since your book?

Dr. Marty Makary:

I know it's amazing. If you go and sort of do as a scout of all of US healthcare and figure out who is actually practicing in a way that is having meaningful results, it turns out that a lot of these innovative models of what I call relationship-based medicine are extremely exciting and successful. Every now and then you meet a doc, could be an old timer, who's been practicing medicine the way they insist it should be practiced. They've basically said, "I don't care about what I'm supposed to do with this billing, coding, throughput model, I may not make a lot of money from it, but patients are hungry for this." And they're doing it and you see these pockets. And when you start sharing the stories of relationship-based medicine, as I had the privilege of

doing in the book a little bit and some other writings, people are like, oh my gosh, you can do this. This makes sense. This is what I want to be a part of. I don't want to be a part of this billing throughput model.

Look, 30% to 40% of the entire cost of healthcare for a particular service, we're talking about a definable service in healthcare, is in the entire back industry of pegging a code, paying a licensing fee from the provider side and the insurer side to process that claim, paying the licensing fee to the AMA code book, which as you know very few doctors are members of the AMA, but the AMA makes a ton of money used for lobbying primarily from that code book licensing fee, then people on both sides to process the claim, then the appeals process, customer service and collections process, which sometimes, as you mentioned, gets predatory, and then on top of that, the patients have to go through some massive negotiation to go on a payment plan. That entire system is 30% to 40%. how do I know that number? Because that's what the transparent pricing model folks are saying they're seeing as a discount when hospitals are willing to post a price for an elective surgery. If they say, hey, here's the standard price, here's not our charge master, but the actual paid amount that we get. Oh, we can post that service on an online marketplace? Sure, we'll post it at 30% to 40% less because it's cash up front, we don't have to go through those money games.

Rob Barshop:

There's almost a crime. We almost have a bait and switch when we get a medical assistant into the primary care clinic. We're bating and switching because we're teaching them medical terminology and giving care and triage and in the end, when you go to a medical clinic of the 14 people that the average patient and doctor are dealing with, whether it's the front desk and the intake, the person that's inputting the HR, the person handing you the clipboard, the that's taking the copay at the end. There's only one triage nurse in there and she's dealing with blood pressure, maybe she's doing a weight, she's giving her scales, she's doing a pulse ox, and that's the only care you're going to see from that entire staff. The rest of them are all money handlers and administrative burden people.

12 to 14 people in the average exam are all, as you call them, transactional assistants as opposed to medical assistants. And then the average doctor that's independent is making about 18 cents on the dollar of that exam and if they work for a hospital, it could be as low as 8 cents on the dollar. That is not very efficient, is it?

Dr. Marty Makary:

And then the doc is told, "Okay, the solution to this problem is work harder. You'll bring in more money and that will allow you to get out from under this cloud of constantly racing to meet overhead costs, malpractice costs, and these third party costs." And it's just amazing because when you see services... There's one group called Texas Medical Management Company. I think they do elective surgery throughout Texas. It's a network of surgery centers and they offer transparent pricing for procedures. There's an agreed upon price. There's no haggling. There's no army of staff that are hired from each side to sit at the negotiating table each year and negotiate a secret discount. That cost does not exist in this world. There's an agreed upon price and they send you an invoice.

Now, somebody once said, "Hey, my insurance company requires me to fill out this claims processing form. Can you fill this out?" And they said, "No, we only send you an

invoice." And the insurance company said, "Well, we can't do anything with this invoice. You have to follow our claims processing form." And the surgery center was like, "Look, that's your problem. We're giving you a price. It's a very good price." And the reason that's a very good price is we don't have to play those money games.

Rob Barshop:

Keith Smith is the thought leader that started that whole model in Oklahoma, Oklahoma Surgery Center. The model was copied in Texas. And Keith has the best quote of anybody I've ever heard other than you, his quote is that, "Why are we trusting those driving the getaway car to solve the heist?" You spend a lot of time in the White House and in Washington advising on public policy, what are we getting right about C-19 and what have we gotten completely wrong if you were king for a day? Because I know they're listening to you, but I also know that they're not taking all of your advice.

Dr. Marty Makary:

Well, first of all, I'm glad you mentioned Dr. Keith Smith. He's tremendous. And we've had him up at the White House and I'm glad people are listening to them.

COVID is interesting because there are hospitals that have real needs. There were some hospitals that were run by good people that have been on the brink of collapse simply because they serve a lower income community or they're in a rural area, which is a special place in my heart growing up in a very rural area. But this may end up being the most profitable year in the history of hospitals for many hospitals in the United States because some of those cases did not disappear, they're simply backlogged and there's going to be Saturday hours and evening hours and surgery centers are going to be on overdrive to get through that. Plus there's COVID the patient revenue, plus some hospitals did not really have a massive reduction for a sustained period of time. It may have been for a few weeks.

And if we're talking about 150 billion going to hospitals, I want to make sure that money goes to the hospitals that need it, not the hospitals with billion dollar endowments and sitting on giant cash reserves and price gouging patients. As you mentioned, I've been very active in Washington, D.C. to ensure that any money that goes to hospitals is conditional. It's not free because it comes off the backs of everyday American workers. And we forget about those folks, but 80% of America live paycheck to paycheck and half of America has less than $400 of cash on hand and if 14% of America's unemployed right now, most of those will be filing taxes and paying the little the money they have into the tax bowl.

And we're going to give that to hospitals with billions of dollars in cash reserves? No. It should be conditional and it should be conditional in very specific things. And they are the five measures of billing quality that I outlined in the Journal of the American Medical Association earlier this year. Basic principles of billing quality standards by which all hospitals should be able to provide transparent metrics on how they perform, not surprise billing and price gouging and markups, and billing patients for services where there was a never event or a complication, so basic civility in billing practices.

We also have an opportunity right now with COVID to say, can we redesign care? Most industries in the United States are discovering that there is something they've been doing that is been mostly unnecessary. And they're only discovering that now because of COVID. In healthcare, there's a fair bit of that. We're learning do you really need to come in, in person, park

in a parking lot, navigate a campus map, check in with security, sit in a waiting room, talk to a doctor for a urinary tract infection when there's no physical exam, you're just explaining your story? No. It's illogical, it makes no sense.

This COVID-19 period has been a period for us to say, let's streamline care delivery. Let's streamline the FDA process, some of the most ridiculous and burdensome regulatory requirements you would... I don't know whether or not to laugh or cry in the story of how the COVID-19 test in the early testing in January submitted by the University of Washington was told, "Oh, we can't accept this application for your testing system for COVID-19 for the coronavirus because you did not accompany your electronic application with a mail application, a snail mail application, including a CD-ROM with the files of the application burned onto the CD-ROM." That was a valuable six to eight weeks we lost because of that stupid requirement. And so we're stripping down some of those, a ridiculous requirements right now. And I hope we come out with a better healthcare system because of it.

Rob Barshop:

The average listener to this still doesn't know what test is reliable and quick and onsite as opposed to you got to wait several days. Are we getting closer to a test that we can count on so that we can actually start getting some head count on what this looks like for employment?

Dr. Marty Makary:

We are. It's changing every week. There was a tremendous amount of enthusiasm around sort of finger stick, point of care, antibody testing, but it turns out that's not reliable enough to really make conclusions at a population level. And we really reverted back to the venue puncture, needle stick, draw a vial of blood antibody test. Is that tests really that helpful from a public health standpoint? It's one piece of information and it can be helpful to some individuals, but CEO's tell me, "Hey, I want to antibody test all my employees." Okay, well, I tell them, "That's fine, but be prepared that 3% may come back with the antibody. What are you going to do with that information?" Okay, you 3% can come back to work. And I mean, what are you, right?

The testing is getting better, but personally and this is my opinion and I know it's a minority opinion in public health, it's a minority opinion at my own Johns Hopkins School of Public Health, I don't think testing is the silver bullet. I don't think that somehow the notion that if you test everyone in America four times a week, we will conquer this. It is one tool in the toolbox, but remember the best indicator of whether or not you have the infection is whether or not you have symptoms. And we're relying on people who think they might've been exposed who have no symptoms, are feeling great to come in and get tested and then we tell them, "You actually have the infection, might be contagious, quarantine yourself." Okay, that's good, but it's a small fraction of what we're going to do to really fight this infection both now and in the fall. Because remember, in the fall, contact tracing and isolation, we get a complete do over and it is important.

I'm not downplaying it, but what do you do when somebody in New York says, "I think I might've been exposed. I want to get tested." They test positive and then the contract tracer hired by the local government says, "Okay, where have you been in the last seven days?" And they say, "Well, I just took the E train through Grand Central Station and I live on the 86th floor of my apartment building." What do you do with that information? The reality is what you do is the same thing as if the test was negative. You tell somebody: distance, wear a mask when you

cannot maintain distancing, use hygiene, wash your hands, and all these things. Whenever the viral burden in a society is above a certain level, we need everyone to follow those basic protocols of distancing, hygiene, and even masks when distancing can't be achieved.

Rob Barshop:

I live in a low density state in Houston, Texas. We have less people per square mile than New York has in it's fondest dreams. We opened the states up in Georgia and Texas. Are we making a mistake by opening up too soon in these less dense states that have basically no, Atlanta has trains and commuters. We don't have anything like that in Texas. There's very little train activity and or bus even. People are in their cars going on the highways everywhere. Are we making mistakes in these states that are less dense and have less mass transit?

Dr. Marty Makary:

Well, as you may know, Ron, I was very much calling for the shutdown. I was very much calling for sheltering and early on if you would've told me, "Hey, here's somebody two months ago that really believes we should go into a shutdown." I would have said, "Oh good, thank goodness. Somebody who actually gets it." I was calling for this shut down because we didn't know what we were working with. We were worried about rationing at the doorsteps of hospitals. By the way, New York came pretty darn close to rationing care. And we needed to do everything. Everything possible. We didn't have good information. But we said, as a country, just for now, just stay at your home. We probably should have said on your property or outdoors or in a park or something, but we told people to take it easy. And we saved probably hundreds of thousands of lives because of that.

But now we have more information. The data has accrued and we've got to evolve our strategy and that new data is teaching us that the virus is associated with high population density, public transit. It's associated with mass gatherings, city to city transmission, nursing homes, certain at-risk populations and for young healthy people, the reality is, the data says that it is very hard for this chronic virus to hurt somebody who's young and healthy. I'm not suggesting they be reckless or infect people who are at risk, but I'm just saying, we've got to learn from the data. The data are very clear now. And one of those important pieces of information is that there's an association of the coronavirus with climate. It appears to be a seasonal virus as are the other four coronaviruses. They are seasonal coronaviruses. And so the states in the south, look, I don't know if it's because of the climate association or the heat or the humidity or the UV light or the fact that folks in those southern states are more likely to be doing activities outdoors than indoors, which we know is safer, but it appears that the seasonality was a major factor and is a major factor right now.

And there's also something to note as we go into the fall and winter, because remember we had this coronavirus with what, one third of our winter, maybe a third of our cold season. Imagine going into the fall and winter without mitigation with an entire cold season of an entire winter. In fact, the states that got hit the hardest are the states with the longer cold seasons: Illinois, Washington state, Massachusetts, New Jersey, New York.

Rob Barshop:

I'm [inaudible 00:24:45] in the origin of disease as much I am as how do we deal with what we have now. You wrote in the New York Times that masks are essential now kind of as a going

forward strategy. Is it important that we be getting N95 masks as opposed to the three or four ply masks or are they just fine?

Dr. Marty Makary:

I think the level three masks are fine without the N95 feature. I think we're talking about massively reducing, not eliminating, but reducing the burden of airborne droplets. The level three masks are fine. And remember these are temporary strategies as long as the viral burden in the community is above a certain appreciable risk. I think we're going to have a period of July, August, maybe even early September, where we can take off those masks when we're unable to achieve distancing. Remember the idea is not when you go to bed alone, you sleep with a mask on. The idea is that if you're in a meat packing facility or you cannot maintain social distance at some certain some activity, then you should wear a mask.

Rob Barshop:

I've had so many picnics outdoors since I read you. That's a good thing to do. Don't worry about any transmission outside as long as you're keeping your distance. I'm doing a lot more of that. Nursing homes you brought up in your latest transmission. The 30% of the deaths are nursing home-related. Wow. Wow. Wow. Wow. What are we doing wrong there? Are the hospitals admitting super carriers into these nursing homes?

Dr. Marty Makary:

Well, it is one of the great tragedies that we will look back on and realize this was mostly avoidable. And what happened was we allowed COVID positive patients to go to a nursing home or a longterm care facility. Unfortunately, this is nothing we should be proud of, but sometimes in the hospital we've adopted a mentality of, okay, we've got to get them out of the hospital, get them out of the hospital, get them out of the hospital and where they go to has been a secondary consideration. And look, it may be a function of burnout, may be a function of our broken system, but when we're in the bunker in a hospital, sometimes for some clinicians, the mentality of just get them to the next spot, the enthusiasm to do that has superseded the considerations for safety and with COVID, we got burned really bad.

Patients left the hospital even though they didn't have severe symptoms. They had the so-called non hospitalizable level symptoms, moderate or mild. And it was okay, they can go back to their bed in the nursing home. That ended up being a horrible mistake. There's even accounts in some States where the state health commissioner insisted on that, they wanted that. And so we're going to look back and realize that was a massive mistake. Half of the deaths in New Jersey were nursing home or longterm care residents or staff and outbreaks have been common in nursing homes. And right now we need massive protection, firewalls around nursing homes so that people can still have some interaction with family, through glass or the visitors are tested or show signs of having been tested. Staff are tested frequently, at least twice a week. Residents are tested frequently, at least twice a week, as long as there's a certain appreciable risk in that local community.

Rob Barshop:

Very practical. Great, great suggestions. Love the bullet points. The last question I have, and I want to be conscious of your time because I think you have a hard stop, Marty, is what does

business adaptation look like? Is that a heat sensor is monitoring and when your forehead is a little oranger than the next guy that you're turned away and sent back home by the security guard? What is exactly business adaptation going to roll out to look like?

Dr. Marty Makary:

Well, I think we're figuring that out together. And I talked to a lot of business leaders that ask, "How can we redesign our processes?" But let's look at the businesses that have done fairly well or at least managed the virus in functioning throughout this entire period. Let's first look at the businesses that have failed at it. Meat packing. They were not able to maintain social distancing and took very little or no precautions when that social distance was not achievable.

Now, let's look at another story that I would argue is as a success, grocery stores. Grocery stores have been functioning through the entire eye of the hurricane of COVID-19 and they have not been sources of outbreaks and they've not been hotspots. And that is because they have put it in plexiglass and removed certain salad bars where you normally would share. They've insisted on masks. They've redesigned a lot of their processes, touchless transactions. They've done a lot to reduce transmission risk through constant cleaning and hygiene and protocols for their employees. And those are businesses that we can look back and learn from.

Hospital's the same. I was in the hospital yesterday. Every person in the building was wearing a mask and the cleaning staff was running around cleaning stuff. For now, they're holding off. We're not having high schools do tours of the hospital right now. We can learn a lot from these industries. And it may be that schools reopen and I think they should most likely reopen in the country in this fall, assuming we've got a manageable level of the viral burden, but maybe they don't take those big field trips that they normally would take. And so maybe they can adjust to, businesses can adjust to the times for the time being until the therapeutic is mature.

Rob Barshop:

Before we sign off, I'm really seriously worried about America's most important institutions, the churches, the arts. The people that support these buildings and these bricks and mortar mostly have gray hair. And I don't know about you, but most of the gray hairs I know don't want to go to a big crowded building anymore and sit next to people. I worry that the support for the arts and for the religious institutions that are so important are going to start drying up as people physically quit going to those bricks and mortar. A Zoom meeting only does it for you so much when you're trying to get the glory of God, whether it's through a symphony or through a preacher or a rabbi. I'm concerned that that might be a post-apocalyptic collapse of institutions that are already weak.

Dr. Marty Makary:

Well, I'm concerned as well. Thanks for raising it. Living in Baltimore, Maryland. I look at those of you living in Texas and the southern states as saying, "Well, at least you've got good weather." Maybe there's more ways to innovate by using the outdoors and having outdoor services. Zoom, as you said ,is limited. It's just not the same. Can you imagine watching an NFL game on Zoom? You got to feel the roar of the stadium. This is our livelihood. This is our life. And I think some things we can adapt to and other things we just need to say, we got to postpone. For church services and other places of worship, I'm really hoping that we can utilize the outdoors until the viral burden in the local community is low enough that we can just get back to life as usual.

Rob Barshop:

Well, I'm going to suggest that the listener, we did not talk about it much, this we'll do this another time, but The Price We Pay: What Broke American Healthcare and How To Fix It, amazing read. It's a great about a 14 hour Audible. And Unaccountable, which came out a few years ago, What Hospitals Won't Tell You and How Transparency Can Revolutionize Healthcare, did that make you a pariah among the hospitals? Were you suddenly, you can't get a passport into your favorite hospitals anymore because you broke the lid off?

Dr. Marty Makary:

Maybe for a little bit, but every single thing in the book came true. All the transparency initiatives, the public reporting of certain parameters. It ended up being a little prophetic more so than it was a nemesis.

Rob Barshop:

Marty, if people want to read your books, they know where to find them, but if they want to learn more you and get in touch with you, do you have a Twitter handle you want to reach out to people with or how do people find you?

Dr. Marty Makary:

Sure. I'm on all social media, Marty Makary. I'm on Twitter at Marty Makary and love hearing from folks and hearing about experiences of people on the front lines because really, that's how we, those of us in academics, learn is just from listening. Thanks for asking.

Rob Barshop:

I always ask the question at the end of my interviews and it's what banner would you want to fly over America if you could say one thing? And actually, for the first time in 70 episodes, I'm going to write your banner for you. Can I say what I think your banner should say?

Dr. Marty Makary:

Please.

Rob Barshop:

And I want to say it the way you can. I'm going to try to imitate you. People are just getting hammered out there.

Dr. Marty Makary:

That's right.

Rob Barshop:

That's a Marty Makary original and it's actually just true to its very bones.

Dr. Marty Makary:

Well, I thank you. And I do think there's a massive disconnect between this sort of elitism that you hear and see in the media and those who claim to sort of speak on the behalf of everybody. But as I toured the country for The Price We Pay, I met everyday Americans who work harder than I do for far less money and they had my respect. I do believe that people are just getting crushed out that are doing the right thing.

Rob Barshop:

I want to tell you all folks also as we sign off and thank you, Marty, for this time you allocated. I know you're about as busy as you've ever been in your career, but Marty is a public speaker. He is self-effacing and humble, but he is funny as hell. He got about 20 laugh lines in the 20 minute talk he gave at the Health Rosetta in Dallas, Texas. And Marty, there is a rumor that you are moving to Texas either part time or full time sometime soon. Is that even in the cards for you?

Dr. Marty Makary:

I do love Texas. I'm down there frequently. I do enjoy getting down there. San Antonio, Austin, Dallas, Houston. Thank you. I it's one of my favorite place.

Rob Barshop:

Great. So it's a false rumor. Thanks again for your time and we'll look forward to getting you back on the show again soon.

Dr. Marty Makary:

Great. Thanks for having me.

Rob Barshop:

Thank you for listening. You want to shake things up? There's two things you can do for us. One, go to primarycarecures.com for show notes and links to our guests and number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcast and subscribing and leave us a review. It helps our megaphone more than you know. Until next episode.