

BOOKS AND IDEAS PODCAST

with

Ginger Campbell, MD

[Episode #54](#)

Interview with Michael Saag, MD, Author of *Positive: One Doctor's Personal Encounters with Death, Life, and the US Healthcare System*

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This is [Episode 54](#) of *Books and Ideas*, and I'm your host Dr. Ginger Campbell. For detailed show notes and a free episode transcript, please visit our website at booksandideas.com. You can leave feedback on our fan pages on [Facebook](#) or [Google+](#), or send me email at docartemis@gmail.com.

Today's episode is an interview with [Dr. Michael Saag](#), author of a compelling new book entitled, [Positive: One Doctor's Personal Encounters with Death, Life, and the US Healthcare system](#). Many of you have probably never heard of Michael Saag, but he is one of the physician researchers who has led the fight against HIV and AIDS.

In *Positive*, Dr. Saag shares the inside story of how HIV has been transformed from a death sentence to a controllable chronic medical condition. But he also shares his insider's view of what's wrong with the U.S. healthcare system, along with his unique perspective on what we can do to change things. Now, your gut response may be that you aren't interested in either one of these topics, but I hope you will keep listening, because what you learn may surprise you.

This is a special episode for me for several reasons. First, as a physician, I found the story of the battle against HIV both interesting and inspiring. Dr. Saag has spent almost his entire career at my medical school, the [University of Alabama School of Medicine](#), which is commonly called ‘UAB School of Medicine’ because it is located in Birmingham.

As an alumnus of UAB, I have been proud of its world-leading efforts in [HIV](#) research, but I didn’t really know the details until I read Dr. Saag’s book. During the interview, Dr. Saag and I do reminisce briefly about a few of our favorite mentors. Unfortunately, many of these people are no longer with us, but clearly Michael Saag is continuing their tradition of leadership and caring.

Besides the UAB connection, the other thing that makes this episode special to me is that I share Dr. Saag’s concern about the current obstacles to practicing good medicine in the United States. I will remind you about this again after the interview, but I would love to hear feedback from listeners, both inside and outside the U.S.

Please do listen all the way to the end for my comments after the interview, because I will be making an important announcement about the future of [Books and Ideas](#) and my other show, the [Brain Science Podcast](#).

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INTERVIEW

Dr. Campbell: My guest today is [Dr. Michael Saag](#) from the University of Alabama School of Medicine [Center for AIDS Research](#). Mike, it’s great to have you on *Books and Ideas* today.

Dr. Saag: Thanks for having me.

Dr. Campbell: Usually I start out by asking my guests to tell me a little bit about themselves; but since your book is an autobiography, that seems a little redundant. So, instead I'm going to jump into a more-focused question and ask you when did you decide you wanted to be a physician.

Dr. Saag: Well, according to my mother, it was when I was born. But I actually started thinking about it in my sort of eight-, nine-, ten-year-old time frame. I remember writing a book report on the ear when I was in third grade. I think I had innate interest in becoming a physician that early.

And I also had a number of experiences, some of which I outline in the book, where I was doing construction work as a ten-year-old, eleven-year-old, and realizing as I was painting fences in the hot sun of the summer that I didn't think I wanted to do this for the rest of my life. So, it was motivating to do well in school and try to make it to medical school.

Dr. Campbell: Did you go to medical school in your home town?

Dr. Saag: I did. I was born and raised in Louisville, and I went to [Tulane University](#) undergraduate school in New Orleans and majored in chemistry, and then came back to the [University of Louisville](#) for medical school.

Dr. Campbell: And then you came to [UAB](#) as a resident. What year was that?

Dr. Saag: 1981; ironically, in June of 1981, when the first cases of HIV were just being described. So, it's a little bit of a coincidence. But I didn't go there to become an [ID doctor](#)—certainly not an HIV doctor—I went there to be another bald Jewish cardiologist, because I thought the world needed one more.

Dr. Campbell: I got a kick out of that, because I was on a podcast called [Medical School HQ](#) recently¹—the guy interviews a lot of doctors from various specialties, and helping kids with thinking about getting into medical school—and somebody thought that I was really indecisive because I had gone through various specialty interests.

And he said, ‘I thought the guest who decided he wanted to be a cardiologist when he was four years old was a lot more focused.’ And I was thinking *how do you decide to be a cardiologist when you’re four years old?*

Dr. Saag: Tough—or even when you’re 24 years old. Because there are a lot of groups that might find interest in this book, but I think especially those who are in training, either in nursing or medicine, who might find some comfort in the fact that it’s not a straight line from when you start your education to what you end up becoming as a healthcare provider.

And my story is, I think, representative of the vast majority of people, where we follow opportunities, follow our heart, and end up deciding on what we want to do long-term based on experience and a lot of soul searching.

Dr. Campbell: And individual episodes with individual patients make a big difference.

Dr. Saag: Patients, and opportunity, and mentors, and all of that sort of comes together into this incredible mix that I guess we’d call *soup* at some point. We have to be open to our experiences, and follow our gut in terms of where we end up at the end of the day.

¹ Dr. Campbell’s interview is Episode 64: <http://medicalschoollhq.net/mshq-064-the-brain-science-podcast-host-ginger-campbell-shares-her-journey/>

Dr. Campbell: Well, since I went to medical school at UAB and sort of overlapped you—I graduated in 1984—I don’t think I ever did any rotations that involved you, even though I think you were the chief resident when I was there.

I wasn’t really interested in medicine at the time; I was more interested in surgical subspecialties, to be honest. So, [Kurt Niemann](#) was my person that I admired the most.

Dr. Saag: Orthopedic surgeon.

Dr. Campbell: Yes. And in medicine, it was [Ben Branscomb](#).

Dr. Saag: Yes, pulmonary doc; great guy, wonderful teacher, and excellent role model for a lot of people.

Dr. Campbell: Yes, because he spent extra time with the medical students—which was very unusual.

Dr. Saag: Yes, and he just had that special heart when he took care of patients and when he taught people. He really cares a lot about his communication and his ability to connect with people.

Dr. Campbell: We didn’t get that many opportunities to see what it meant to have a bedside manner; and he was one of those.

So, you’ve spent over 25 years helping lead the fight against HIV and [AIDS](#). But before we talk about that, I’m curious; why did you decide to write a book?

Dr. Saag: Anger, basically. And it wasn’t anger about AIDS, it was anger about our healthcare system, which I find extraordinarily dysfunctional, chaotic, fragmented, and difficult for the average person—or in some cases, even the sophisticated person—to navigate.

And what really struck me is when I was attending or when I am attending on the general medicine service and patients get presented to me, oftentimes it will be a patient who has a certain condition, and then another patient and another patient might have the same condition. And what we do for them can be very, very different based on what type of health insurance they have or don't have.

And when the medical students or the house staff present these cases to me, the different approaches just sort of roll right off the tip of their tongue without any additional thought. I will pull back and say, 'Guys, do you realize that we just saw three different patients with the same condition, and we're doing three different things to try to take care of them because of what the system will allow us to provide for them or not?'

And we, as a group—and as a society, I would say—have become totally anergic to this. It's like we don't even respond anymore. It just is so much engrained as a part of what we do that we just blow on through it as if it's no big deal. But it's a huge deal. And I just got tired of putting up with that every day, got angry and said *I'm going to write a book*.

Dr. Campbell: Well, I'm with you. I mean when I was an intern back around the same time as you, at least we had some resources for the people who didn't have insurance. And it seems like now we have nothing. The situation has definitely gotten progressively worse.

Dr. Saag: And it will not get any better until we, as a group of people—as a society, in essence—become so activated that we lead the charge for change. Healthcare providers, in particular, are in a unique position to help lead that charge. But for me, the way the book brings us all together by telling the story of HIV, which was converted from an almost certain death sentence to a chronic manageable condition in 30 years, is pretty darn remarkable.

The way that happened was patients, families, providers, pharmaceutical companies, government, academia, everyone pulled together in the same direction. And a lot of the energy for that galvanization, if you will, of effort in one direction was really sparked and led by activists—people who would not let us say *we're doing all we can*. They would say *doing all you can is not enough; you need to do more—now*.

And groups like [ACT UP](#) in New York, or the [Gay Men's Health Crisis](#) in New York, or [Project Inform](#) in San Francisco, and hundreds of other entities (most notably buyers clubs, for example, like is portrayed to some degree in the [Dallas Buyers Club](#), but for me locally it was the Atlanta Buyers Club) who had a much better approach to getting treatments for their group, not by setting up a for-profit entity, but a not-for-profit entity.

The point being, though, that these activists created heat that brought all of us together and pulling in the same direction. And what I'd like to see, what I hope the book is able to accomplish is kind of a wake-up call to all of us to say *enough; we're not putting up with this anymore, and we're going to insist on change that puts patients first, and lets people who are engaged in the delivery of care have more control of the destiny of both the providers but especially the patients*.

Dr. Campbell: Right. So, I would like to sort of split the rest of our time between that issue and hitting the highlights about the battle against HIV, partly because I realized in reading your book how little I actually know about where things stand. And I figured that that might be typical of a lot of physicians—and especially, regular people—who don't deal with HIV on a day-to-day basis like you do.

So, for the sake of our younger listeners, can you start out by just taking us back to the beginning of HIV?

Dr. Saag: Right. So, imagine a time when there was no knowledge about a disease such as this, and suddenly in emergency rooms and in hospitals around the country, but especially in urban areas, young people started showing up with these very unusual infections.

And they're so-called [opportunistic infections](#), because these are organisms that we come into contact with every day—through water, and potentially air and food—but that our bodies, with a healthy immune system, just fight off, and we never get sick or get infected, or certainly don't develop disease from them. But when the immune system gets weakened, those organisms take advantage of the opportunity of a weakened immune system to set up a very vicious and life-threatening disease state.

And so, that was starting to happen. These folks were showing up in emergency rooms with various disorders like [pneumocystis pneumonia](#), or [cryptococcal meningitis](#), or [toxoplasma encephalitis](#), and on and on. And for the doctors and nurses providing care for them, it was a total mystery. So, from 1981 to 1983, the [Centers for Disease Control](#) and a lot of [epidemiologists](#) around the country, and the world, for that matter, just started digging in and saying *what do these people have in common?*

And it took a couple years to see the pattern emerging. Initially it was thought to only be involved with gay men. And then, they said *wait a minute, some people from Haiti are coming down with this; and here are some heroin users who are coming down with this; and some of the [hemophiliacs](#) are getting it*. So, initially it was called 'the disease of the four H's'—those four populations of people. And then, suddenly women started coming in; and they started seeing some infants, born to women who seemed to have this disorder, coming down with these disorders.

And it became clear after about three years of study that this was likely from a transmissible agent. And by 1983, 1984, the virus that causes AIDS—the human immunodeficiency virus—was discovered. Once that happened, then things began to change pretty quickly. Once we knew we were dealing with an infectious agent, we could rapidly develop some tests—in this case, the [ELISA test](#), the [Western blot](#)—that could detect who was infected and who wasn't.

And we could start staging the infection by looking at the so-called [CD4 count](#), which is a cell of the immune system that normally hovers between 500 and 1500 cells per cubic microliter, that when those counts drop below 200, and certainly below 50, then that's the time when the highest risk for some of these opportunistic infections started to happen.

So, the picture started coming together in the first five years. And then, once the virus was discovered, the folks at the [National Cancer Institute](#) and elsewhere started pulling drugs off the shelf, trying to inhibit the virus in its tissue culture, and found one drug that was quite effective. And that drug was [AZT](#).

AZT originally was a drug that was designed to treat cancer in 1964. But it didn't work so well against cancer, so it got put on the shelf. And when the NCI investigators, [Bob Yarchoan](#), [Sam Broder](#), or others, started working with that compound, they saw *wow, it works pretty well against HIV*.

And they went to [Burroughs Wellcome](#), a drug company in North Carolina, and they co-developed the drug and showed by 1987 that it prevented death among people with very advanced disease—those who had had prior pneumocystis disease, or had a CD4 count less than 200. And then we were really off to the races in terms of therapy.

So, that's kind of how it all started. But the side stories and the human tragedy is really what I try to highlight in the book. And I would hate to think that we'd ever

forget that or lose that history, because it was incredibly motivating and profoundly sad to see so many talented young people dying, when we couldn't do anything to really help them.

Dr. Campbell: And at what point did you personally decide that you were going to devote your career to this?

Dr. Saag: For me, it was a bit of an evolution—getting back to our original theme of you can't plan your career out too much—but it was really a series of serendipity.

One was that my very first day as an ID fellow here at UAB, I had a clinic—an ID clinic—and a woman was sent to me from Gadsden who was a schoolteacher. And she had just donated blood in May of 1985. And that's precisely the month and time when the blood supply started to be tested for HIV.

And she received a rather curt—in essence, rude—letter from the Red Cross saying, *Hey, we tested your blood, and you've got HTLV3 (or the HIV virus); go see your doctor.* She went to see her doctor, who said, 'I don't necessarily know what to do here; I'm going to send you to the experts in Birmingham.' And that "expert" happened to be me, a first-year fellow.

So, around that time [George Shaw](#) had just moved here, who was working at the National Cancer Institute with Sam Broder and others, and in [Bob Gallo's](#) lab where the virus was co-discovered. And I called him, and we drew a bunch of blood, and it turned out that this woman really wasn't infected with HIV; rather her test was a [false positive](#).

And that turned into a [New England Journal of Medicine](#) paper². Before I knew it, I was engaged in HIV research—not by any kind of forethought and planning, but just by a series of opportunities and accidents, if you will.

Dr. Campbell: Okay. I want to take a moment to make an aside on this whole issue of the false positive, because I think a lot of people—including physicians, unfortunately...

I came from engineering, so it never ceases to amaze me how the biology guys don't always seem to get this idea that almost every test is going to have false positives.

Dr. Saag: Yes. There are limitations; and whenever we order a test or use a test, ideally we should be aware of those, and manage our way through it.

In this particular situation, the first paper I reference was a paper from the *New England Journal of Medicine* that reminded us about the [Bayes' theorem](#), where the positive predictive value—that is, whether a positive test is truly positive—really depends not only on the performance of the test, but also the likelihood that that population of patients you're testing should have the disorder that we're talking about.

In this case, this was a monogamous woman who had never had sex with anybody but her husband, and her husband had tested negative. And when you apply that theorem to this, her likelihood of this being a true positive test was close to less than 10%.

² Saag MS, Britz 1986 "Asymptomatic blood donor with a false positive HTLV-III Western blot." *J. N Engl J Med.* 314(2):118.

And the paper that I quoted for this started off with a great opening line. It said, 'We are a testing society. We test our urine for drugs and our sweat for lies.' And that was a paper by Meyer and Pulcher from 1987, or so.³

At any rate, the lesson that you just referred to is something we should always remember whenever we order a test on anybody.

Dr. Campbell: Yes, I work in the ER, and there's a lot of pressure, partly from patients, to do tests you know you don't need. This is not just because of Bayes' theorem, but also just plain old [Murphy](#)—the less likely they are to have it, the more likely they are to have a false positive.

Dr. Saag: Absolutely.

Dr. Campbell: And usually it's not quite as bad as being told you have HIV in 1985, when that's a death sentence; but it still can lead to a lot of, at the very least unnecessary more testing and expense.

I want to talk some more about your research and the key discoveries, but I think maybe we might talk briefly about the [1917 Clinic](#), since those are interconnected, and why it's so important.

Dr. Saag: Right. So, that was also a bit of an accident—in a good way.

After I'd worked with George on this false positive story, I went into the lab and happened to stumble onto this notion that HIV, when it infected someone, evolved into a swarm of viruses that are all genetically distinct, highly related, coming from a single initial virus that infected someone.

³ I haven't been able to find this reference.

This is a so-called [quasispecies](#), so that if I drew blood from any patient sometime after they got infected, you'd see a bunch of highly-related family of viruses. And we discovered that in about my first two to three weeks in the lab—which was incredibly lucky for me.

And then I found myself, as a first-year fellow, traveling around the country giving lectures on this topic to all kinds of people. And I found myself at the [University of California at San Francisco](#) in December of 1986. I was giving a lecture, and I spent the rest of the day touring their clinic. They had, I think the first HIV clinic in the world really, dedicated, at [San Francisco General Hospital](#). And I just asked them one question: *If you guys were starting over again, how would you design a clinic?*

And I took lots of notes and came back to Birmingham and threw together this white paper that in essence said *we need to get out in front of the epidemic; we're going to get hit hard the next decade with more and more patients, a lot of them coming home to die from high-impact areas like New York, San Francisco, Miami, Atlanta, etc. We need to be prepared for this.*

And I went to [Claude Bennett](#), who was the chair of medicine at the time. And literally in four minutes of my presentation, he stopped me and said, 'This is a great idea; we need to do this. I'm going to bring you on faculty. Here is some start-up money. Here is a space I'd like you to work out of. Just try not to run in the red.'

Then the 1917 Clinic was born. And I basically had a tremendous advantage of having drawn on the experience—six, seven years of experience—from San Francisco and could hit the ground running with a really world-class operation.

And I think the main thing that came out of that experience looking at San Francisco was three things: One, that patient care should be delivered out of what

in essence is a medical home, where comprehensive care is delivered, but also social services, access to research, new therapies, all in one place at one time.

The second thing is that every patient, in essence, is on study. This is such a new disease, we should set up a record system that collected information in an organized way that we could go back and evaluate outcomes based on certain presentations in the way people showed up.

This is a very [John Kirklin](#) like approach. He was one of the leading cardiovascular surgeons who, in essence, started the modern-day coronary care units in the '60s, and the notion of every patient being on study was essential.

The third thing was that we collected specimens on every patient—as best we could, with informed consent—and that we would have those specimens available for future research.

And out of the combination of having data and specimens linked together, the first use of [viral load](#) in the world was done here, the first description of viral dynamics—that the virus produces one to ten billion viruses a day, in rapid succession every day, and that that's how it does its damage over time to the immune system, and how it creates inflammation, etc.

So, those are the types of discoveries that came out of the simple advice from San Francisco General in 1986, where they said *study every patient, create a medical home*, and that's what we did.

Dr. Campbell: How about an overview of how HIV did go from a uniformly fatal disease to something that can now be managed as a chronic illness?

Dr. Saag: Well, it wasn't just work out of UAB.

Dr. Campbell: No, I know; you never implied that.

Dr. Saag: I could take the UAB experience, though, and begin to answer your question. Because once we learned this was a virus, once we learned this virus could be inhibited by certain types of drugs in the test tube, then it was just a question of taking those drugs and developing them and applying them into a clinical practice setting.

And that viral dynamics story, where we discovered that there was one to ten billion viruses produced a day, kind of screamed at us that we should be treating everyone from day one as best we can to prevent that longer-term damage from ever happening.

And through close collaborations with the pharmaceutical industry, the government supplying funding to do [clinical trials](#) through organized networks, we rapidly were able to find new drugs, combinations of drugs that could inhibit the virus replication really about 100%. That was discovered around 1994, 1995, and it became known as the [HAART](#) therapy—highly-active antiviral therapy. That therapy became available on a more widespread basis in 1996.

I liken the entire experience, for those folks who've ever been to Washington on the Mall and you visit the [Viet Nam Memorial](#), when you go into that memorial, you start off at ground-level, and you start descending deeper and deeper and deeper into this seeming abyss of just horribleness—names accumulating. But at some point, when it seems like it can't get any worse, it pivots ninety degrees, and then you start coming out.

And that's what HIV was like. We went deeper and deeper and deeper, and then we had this pivotal moment where we realized that if we stopped the virus from replicating, we could convert this from a death sentence to something we could manage. And that's precisely what happened.

And as more drugs got developed—safer, better-tolerated, one more effective than the other—nowadays, in 2014, we're able to find someone at age, say 30, who's newly-diagnosed, put them on a regimen that's one pill once a day, oftentimes, and if they take that pill every day on time like they're supposed to, then two good things happen: they won't develop progressive disease from HIV, and they won't transmit the virus to anyone else.

And so, it's a double win. And that's all happened over the 30 years from the time the first cases were seen in 1981 to the present day. It's been a remarkable success story.

Dr. Campbell: Yes. And I sort of want to get that out. You probably feel like everyone should know it; but I think maybe they don't.

In 1988, I was working in a walk-in clinic and had an HIV patient come in who had an abscess that no one wanted to drain. And I agreed to do it. And then, of course, I was nervous and stuck myself. And I remember I didn't want to be tested; because AZT was just out, and I was kind of like *okay, if I'm positive it's just going to mean all this prejudice against me. And I'm going to die anyway. I think I'd rather not know.*

So, now the argument you make very strongly in the book is that everyone ought to be tested. Would you talk about that briefly?

Dr. Saag: Yes. And I think your story highlights why, in 1988, I was not pushing for universal testing. Because what could we offer them besides a death sentence? Maybe a little bit of AZT; but for the most part, if I tested everyone, I had very little to offer them.

But at that turning point, as we pivoted to the better days of today, now if I get that person at age 30 or 20—whatever age they are—and I get them on treatment

and they have success, they're going to live a near-normal, if not totally normal lifespan.

And so, I've said to a lot of people—and they kind of look at me crazy—if you said at age 20 I had the choice and I had to pick one of two, either HIV or type 1 diabetes, I'd take HIV in a heartbeat. Because the complications of HIV nowadays are much, much less than complications of type 1 diabetes, for example.

So, now that we have treatments that can achieve those types of outcomes that we have to offer people, yes, we should be testing everyone. And as I say, anyone who is sexually active or has even thought about becoming sexually active should be tested for HIV.

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Dr. Saag's book, *Positive*, is not yet available, so I would recommend [*Mountains Beyond Mountains*](#), by Tracy Kidder. This is the story of [Dr. Paul Farmer](#). Like Dr. Saag, Dr. Farmer is an infectious disease specialist, and this is the story of his battle against HIV in Haiti. It is a truly inspiring book which, like Saag's, reminds us that being a physician is really about caring for people, one at a time.

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Dr. Campbell: Okay; well, I guess now I'm almost ready to talk about the big issue. But I want to ask you do you have anything else you want to say about HIV before we talk about the U.S. healthcare system?

Dr. Saag: Yes. Well, as a segue to talking about the healthcare system, again, the reason I put these two topics together in one book was because I saw tremendous parallels between the fight against HIV and the struggle to have a sane healthcare system in the United States.

In essence, the lessons that we learned from coming together to convert HIV from a certain death sentence to a chronic manageable condition, those same lessons can be applied to changing our healthcare system for the better. And what it requires, first and foremost, is a recognition that there is a problem. If the book does nothing else but just highlight that, I would be a happy guy.

This transcends the discussion *is Obamacare good or bad*. That is not the question. The question is *what does our healthcare system look like; how does it perform relative to other healthcare systems in the developed world?*

And coincidentally—and fortunately for me—when I was writing the book, the [Institute of Medicine](#) came out with a report that compared health outcomes, of many different types, among 29 industrialized countries. And if I had asked the average person on the street who did they think did the best, I'd guess 90% of people on the street would say, *Well, the U.S. is number one; we're number one*.

The fact is, we're somewhere between number 23 and number 29 out of 29 countries, for almost every healthcare outcome except for two. For women, if they're able to make it to age 90, from that point forward we have the best healthcare outcomes in the world. And the second is in cost; we cost twice as much as any other healthcare systems in the world.

Those are two indisputable facts. And why we put up with this, I am totally clueless about; except that we, I guess, feel unempowered to change it. And hopefully, we can begin to change it.

Dr. Campbell: Several years ago I interviewed⁴ [Dr. Robert Martensen](#), from the [NIH](#) museum, about his book which was called, [*A Life Worth Living: A Doctor's Reflection on Illness in a High-Tech Era*](#). And he made a point that really stuck with me.

We were talking, actually, about end of life care for like elderly people. He said it would be one thing if we had decided that we were going to have the best last six months of life anywhere in the world, and we were going to spend our money doing that—then that would be one thing. But we're spending all this money, and we're not getting any bang for the buck.

Dr. Saag: That's right. And we're not being very strategic. One of the best images that I've seen that describes how we should be thinking about healthcare was shown to me by a guy who leads the [National Health Services](#) in Great Britain, who leads their cost effectiveness group.

And in essence, the image is think of a king-size bed and a bunch of kids who are all lined up lying in that king-size bed at the pillows. And let's say there are seven of them side-by-side in the bed. And on one side of the bed, there's another kid trying to get in. So, he has lifted up the covers, and he's pushing those guys over so that they can make room for him to get in. And as he does that, the one on the other end falls out of the bed.

The take-home point is crystal clear: we have limited resources, and whatever we decide to do for one, we have to understand that—whether we like it or not—that means we're not going to be able to do something for somebody else. All we tend to think about, as providers and as a society, is that we want to do everything for every patient that we see, as if resources are unlimited.

⁴ Robert Martensen was interviewed in [Episode 28](#) and [Episode 29](#).

The sad truth is resources are indeed limited. And if we keep approaching healthcare as an unlimited resource, when it is not unlimited, we're going to get ourselves into more and more spending inefficiencies, and much like this guy talked about, spending a lot of money on the last year, or two, or six months of life, while at the same time not spending money on preventative measures and other things that we know work well, because we just don't have the resources being applied in that direction.

Dr. Campbell: But I think that in the backs of their minds, people actually do understand that resources are limited. If you look at what happened with the [Affordable Healthcare Act](#) and the [elimination of the public option](#), it's like *okay, I've got my health insurance, and I want to make sure that I keep mine whether you ever get any or not.*

Dr. Saag: Yes. And that's unfortunate, because for the healthcare options, that's how it gets paid for. But what we're ignoring when we make that argument is that the people without health insurance still get care provided, even if they can't afford it.

So, they show up in our emergency rooms because they can't afford to go to a primary care provider. So, they have some catastrophe, or some urgent illness that drives them to the emergency room, where costs are somewhere between seven and ten times higher, and then they generate a bill, they come in the hospital and generate another bill, and they come out.

Well, they can't afford to pay the bill. So, who pays? Well, the hospital is not going to suck it up and pay out of the goodness of their heart. So, what we do is we overcharge the people with insurance to cover the costs of the people who are uninsured. I mean can you think of a more inefficient way to deliver healthcare? It's crazy!

So, what we need to do is kind of pull back and say if we provided care for everyone, or at least assured payment for everyone, through some sort of mechanism... It doesn't have to be government. The obvious immediate thought was maybe it would be a government system; it doesn't have to be.

But we have to have some availability of coverage for everyone, at at least a base level, so that those people could get preventative healthcare, could have somewhere to go besides an emergency room whenever they start to feel sick, and get treated earlier, I think those two things alone would help our overall performance compared to other industrialized countries.

But until we do that, we don't have a chance. And elimination of the public option in the Affordable Care Act, I think was one of the most devastating decisions made in the course of the development of that bill, because that was our best hope to bring healthcare costs under control to some degree, and to assure access to care for more people.

Dr. Campbell: Yes, I felt like it just pretty much gutted the bill, and then you're basically just passing a bad bill to say that you've done it.

Dr. Saag: To me, the Affordable Care Act, or Obamacare, is an important first step, but it's not—hopefully—the last step.

Because, you're right, it's flawed. I think everyone recognizes that. But we need to move on with the same principles. People who say they want competition in the marketplace, well, having [exchanges](#) is a form of competition at a level where you actually can make a choice between insurance company A, B, or C, assuming the insurance companies participate in the exchanges.

And in my view—I think like you're implying—of having a public option, just say *Okay, I'll take the government plan*. You don't have to take it; but if you chose to take it, that would be your choice. And what's wrong with that?

By the way, a lot of people don't realize where the Affordable Care Act came from—you probably know, because you've kept up with this; but a lot of people don't. Originally this idea was proposed by the [Heritage Foundation](#) in 1994. The Heritage Foundation is a sort of more right-wing-leaning think tank. I think [Jim DeMint](#) is now the head of it.

But at the time, it was an alternative plan to what [Hillary Clinton](#) was trying to develop as part of her [solution for healthcare reform](#). And they came up with, in essence, the entire concept of what is now called the Affordable Care Act. [Mitt Romney](#) in the early 2000's implemented that [plan](#) in Massachusetts.

How did it work out? Pretty well. 98% of the people in Massachusetts have health insurance coverage of some sort. And healthcare expenses for the time since it's been implemented have been kept lower, and in fact have decreased, as far as hospitalization in Massachusetts, since it was implemented.

I don't understand, for the life of me, why an idea that was generated in the Republican Party is so vehemently opposed by the Republican Party today. It doesn't make sense to me. I don't get it. But that's the truth.

Dr. Campbell: One of the issues that you mentioned in the book, that I have to say was a little bit something I hadn't really thought about, was you said that the leading cause of personal bankruptcies—I think this is correct—is healthcare disasters.

Dr. Saag: That's correct.

Dr. Campbell: I think that people who have insurance tend not to realize how fragile their grasp on that actually is.

Dr. Saag: Right. So, here are the facts. Among people in the United States who have declared [personal bankruptcy](#), two-thirds of those bankruptcies were

precipitated by a medical bill. Seventy-five percent of those people had health insurance. That's a staggering thought.

We say *well, why*. Two reasons: Because their health insurance premiums really weren't terribly good; they didn't cover preexisting conditions, or they had a cap of say \$100,000, or \$500,000. So that, for sure, kept their premiums low, but it came back to bite them later when they got something they didn't anticipate, which might be a catastrophic illness. And so, they exceeded their limits. They were people of some degree of means, so the hospitals and the other debtors came after them and made them pay to the point they went bankrupt.

And the second point is that among those who didn't have health insurance who were poor—desperately poor—well, the hospitals didn't even bother to go after them; they just let them go. So, it's kind of a [Catch-22](#) that the people with insurance had some degree of means—let's say they had a family farm, or they had a small business—those assets would be consumed by trying to pay the debt; whereas, if somebody has a net worth of \$5000 or something, they didn't even bother with them.

So, the people today who are complaining a lot about the Affordable Care Act are those people who say, 'I used to have insurance and my premiums were \$90 a month; now that I've had to go on the Obamacare plan, my health insurance premiums are \$500 a month.' That's all true.

But if you start looking carefully at what that insurance plan was that was for \$90 a month, it didn't really protect them. And if they got a catastrophic illness or something that generated a big bill, they were going to go bankrupt. The Affordable Care Act helps protect them against that for the future, without allowing limits on coverage and without prohibiting coverage of preexisting conditions. And that's what we're paying for with this. You don't get something for nothing.

Dr. Campbell: In the drug arena, which is also another part of the expensiveness of our system—because our medicines cost more than anybody else’s in the rest of the world—I think you have a unique perspective, because you’ve worked with the drug companies, so you kind of know both their good side and their bad side.

Dr. Saag: Right. So, the good side is they do apply high-level science and creative approaches to problem solving and drug development that is motivated by a [profit margin](#)—which is not evil; it’s a good thing. It’s a good thing for them to be motivated that way. So, I don’t want to interfere with that.

On the other hand, though, because we have chaos in our system—where there is not, for example, a [single payer system](#) like a lot of other countries have—we don’t negotiate for lower pricing. So, what happens is a drug or a medical device (let’s take a hip replacement device; this was brought forward in a series of [New York Times](#) articles, and [Time](#) magazine also carried a series on this), if you look at, say a hip replacement device in the U.S., that device might cost \$30,000, just for the actual artificial hip itself.

Well, if you go to Belgium, that device might only cost \$1200. It’s the exact same device. The reason is in the country in Belgium they could negotiate for lower pricing, and in the U.S. it doesn’t happen, because there’s no organization and there’s no, in essence, collective bargaining—and I don’t mean that in a labor way, but a way of negotiating lower pricing for a product.

The end result is the United States, because we’re dramatically over-paying for devices and for drugs—especially the very expensive drugs like cancer chemotherapies—we are paying for the research and development costs of the entire world. It’s all on our backs. And we don’t say a word about it. By becoming more informed, hopefully the public will take this on.

Another thing that aggravates this—and the general public doesn't really see this, for the most part—is that when the Medicare Prescription Drug Act in 2004 (the so-called [Medicare Part D](#)) was passed, it has a specific clause in it, a statutory clause that prohibits the federal government from negotiating with pharmaceutical companies for lower prices—prohibits it. You can imagine who wrote that law.

Dr. Campbell: Yes. It makes you want to just have your congressman shot. Anyone who voted for something like that, who are they representing? It's not me.

Dr. Saag: Right. So, I don't think the general public knows that it really happened. [60 Minutes](#) ran an exposé on it—quite a good one.

Steve Kroft did an exposé and showed that one of the staffers, who basically wrote the language of the law, within months after the law passing resigned from his senate staffing position and was hired as the leader of this pharmaceutical lobbying group with a salary of well over a million dollars. Now, I can't swear to you that those two facts are related, but it seems a bit more than coincidence.

And so, this is how our government operates. And out of all this chaos, and out of all this mixed message, and out of all this anger about healthcare reform, we're overlooking a lot of critical fine-detailed facts that if people become aware of them and we organize ourselves in a way to say *we're not putting up with this anymore*, hopefully we can enact some change.

Dr. Campbell: I thought that I knew a lot of stuff about this, but I actually did learn a lot that I didn't know from your book, including I've been wondering as an ER doc why we can't get [generic drugs](#).

For example, I'd like to prescribe [doxycycline](#) for patients that might have [methicillin-resistant staph](#) skin infections. And they took it off the \$4 list. And

it's like *why?* That drug is a million years old; why should it not be cheap? You wrote in there that they actually pay the companies not to make generic drugs?

Dr. Saag: There are a couple ways that happens. So, a company that goes into the generic business might be bought by a brand-name pharmaceutical company for, let's say \$250,000,000 or \$300,000,000; for those shareholders, how can they say no to that type of deal if it's going to yield the shareholders a lot of profit? And there goes that competition—gone.

So, that happens on one hand. Sometimes the pharmaceutical company, itself, will create a spin-off company that will be overseas that will create generic, but when it's brought back, it doesn't lower prices very much relative to the brand name. And this happens, for example, in the case of [statin](#) therapy.

And then, the most offensive one to me is [colchicine](#), which has been around for decades as a treatment for gout, and until about five or six years ago, was pennies for an entire treatment course. You could buy 100 pills for let's say \$5.00 to \$6.00.

Then some company said, *Oh, well we're going to claim [orphan drug](#) use.* And they did a study that showed, guess what, colchicine works for gout. They filed a new drug application, it got approved, and now they have a [patent](#) on this, that was in the [public domain](#) before, and now the cost of one round of treatment with colchicine is over \$100.00. And we can't do anything about it.

These types of loopholes and craziness that come out of this chaos that we call U.S. healthcare are just intolerable. And that's getting back to your original question: Why did I write the book? I was angry. I still am, and I'd like to see us do something about it.

Dr. Campbell: So, how can we, as physicians, join with our patients to fight all these vested interests that seem to be determined to make as much money as they can before the system collapses?

Dr. Saag: Well, I think it's going to require a lot of things. One, education; understanding what these facts are. And I just skimmed the surface of a lot of the facts that I think could get us organized and started.

Secondly, understanding the enemy, if you will; that there are a lot of people and companies making billions—tens of billions, hundreds of billions—of dollars on our system and on our backs.

And we have to understand that fighting them is a formidable task, because they are making contributions to, in essence, every congressperson's campaign—the winners and the losers—because they want to have a say in all this. And we're swimming upstream against the strong current of political dollars in the millions and tens of millions of magnitude compared to our voice.

And thirdly, we have to join with our patients, as you said, to create a single voice of activism and say, *We just are not going to put up with this anymore; we can do better; we must do better.* Because what's happening is you see it some in the ER when you try to get a treatment for someone and they can't afford it (say doxycycline or something else), but when they leave your ER, you don't see what happens after that, until they come back to your ER with the same problem.

Why? Because you wrote a prescription, but they couldn't get it filled, because they didn't have a primary care doctor, or they didn't have a social worker who could advocate for them. And the fact that we need all of that, and it's not accessible to the majority of people in our country who are trying to access healthcare, that's what's holding us back. We shouldn't put up with it anymore.

Dr. Campbell: Yes, I've seen that the patients now, I won't say they're using it as an excuse, but they don't even try anymore. They'll just say, *I don't have insurance*; therefore, they don't seem to be even interested in finding a medicine they can afford. It's like they've given up.

Dr. Saag: Yes, they have.

Dr. Campbell: And you can't really blame them.

Dr. Saag: No, because it's a path of least resistance. What are their other options? Showing up in an emergency room is the easiest thing for them to do. And they know they're going to get care. It might take a while. It's going to cost a whole lot more. But they're not going to end up paying out of their pocket; we are.

And it's just terribly inefficient. And I'm sure your job as an ER physician would be much more efficient if you didn't have to do the primary care for all the uninsured people who had no other access to primary care.

Dr. Campbell: Well, and then there's actually the people who come because they'd like to get a free Tylenol, since Walmart actually charges for it.

Dr. Saag: Yes, there's stuff like that.

Dr. Campbell: Really.

Dr. Saag: Yes. It's not a very logical, or efficient, or effective system, and we've got to start changing that now.

Dr. Campbell: I wish there was a better way to communicate with patients that we're on the same side. I think that they tend to see us as part of the enemy.

Dr. Saag: Yes. I talk about that a little bit in the book—that story with David. I had people marching on our clinic, for goodness sakes, in 1989. And I was baffled. *Why are they marching on me—us? Of all people! We’ve laid on our sword to start a clinic.*

And he quickly said, ‘Mike, they’re not marching on you; they’re marching on your white coat. You’re the establishment, and you’re the easiest target, because they can see you, and they know you exist, as opposed to some amorphous *them* out there.’

So, I think that’s part of our tall order, as well.

Dr. Campbell: I wanted to go back to the 1917 Clinic for a minute. You, last year, had a big scare when you had a fire right next to your clinic. I was curious as to whether you have been able to do something to safeguard all those specimens and records. I mean if the Clinic had burned down, you would have lost not just the physical clinic, but nearly 30 years’ worth of work.

Dr. Saag: Yes, that’s right. And the sad part was that we had been almost screaming at the city and the bank that owned the property where the building existed to tear the thing down, and they just didn’t act. And despite the fact of our screaming and screaming, it didn’t happen. And finally, in our worst fear, it did catch fire and burn to the ground—killed three people who were living in there to escape the cold of winter.

And to me, that whole experience—that burning building—was a metaphor for our healthcare system. We all see it as a dilapidated building that needs to be torn down so that we can start over and do this in a logical way. But despite all the screaming and yelling, it’s just going unanswered against the wind. And until we recognize that it’s going to take more than just screaming and yelling, it’s

going to take facts, and organization, and activism to get our diseased healthcare delivery system revamped.

So, that's why I'm grateful for at least the Affordable Care Act being passed, with all of its flaws, because I'm hoping it's the first in a series of movements towards a more logical system.

Dr. Campbell: Is there anything I have left out that you would like to talk about before we close?

Dr. Saag: I don't think so; I think we've covered a great deal. I mean the AIDS epidemic, and some of the research, and the conversion to a chronic manageable condition from a certain death sentence; and, again, this thesis that the lessons we can learn from that positive experience, we can hopefully apply to making the necessary changes to make our healthcare system in the United States more efficient, logical, effective.

And I would add one final comment. And that is that we don't think that this costs us anything? Well, think again. Because every time one of our companies has an employee and that employee is having their health insurance paid for by the company, that's \$10,000 per employee that's going out the door, and another \$2000 to \$3000 from the employee, themselves.

Think of that as a tax, not as a benefit. It's a tax. And it makes us relatively non-competitive in a global competitive environment, because the other countries we're competing against, they have taxes that are roughly one-third of what that company is paying for healthcare, and their outcomes are twice as good.

Dr. Campbell: I'm glad you brought that up, because the most common thing I hear, when I mention to people that I think that perhaps a single payer would be a good thing, is they'll say, *Oh, but then you have to wait six months to have surgery.*

Dr. Saag: It's true in certain settings, but it makes sense when it's true. For example, let's say I had a bad knee, and I've got worn cartilage, and I need a knee replacement. I've been putting up with that bad knee for five to seven years. And it's gotten to the point where it needs replacing; everybody agrees with that. If this were the United States, I'd have the knee replacement tomorrow.

Well, it doesn't have to be tomorrow; it could be in two months. I could wait another two months. But if I had a heart attack, I would get treated immediately in these other countries, just like I do in the United States. What they have that we don't have is logic. We're all about getting everything done now. Well, if that's what we want, that's what we get; but we also are going to pay for that.

And so, yes, there are some procedures that are put off, because it doesn't make sense to get them immediately if the health outcome doesn't change based on whether I get it tomorrow vs. two months from now—like a knee replacement. But for the other things, where it's logical and important to act immediately, they do. And in essence, their health outcomes are better than ours.

Dr. Campbell: Yes, you hear the story, *Oh, the person needed bypass surgery or whatever*, but I think that that's really exaggerated.

Dr. Saag: It's not exaggerated, it's just a flat-out lie. It's a flat-out lie.

And what we can also do is friends can talk to friends. And, say you'll find some folks who got healthcare—say in Germany, or Switzerland, or France, or England, or Italy, or wherever—and you'll ask them, *What was your experience like?* And they'll say, *Pretty fabulous*. And then they'll say, *What's amazing to me is I left, and they didn't even give me a bill sometimes*.

Dr. Campbell: Okay. Well, I've overstepped the amount of time I promised that I was going to talk to you, but I really have enjoyed it.

Dr. Saag: Thank you so much, Ginger, for the interview. I appreciate your taking time to do the podcast.

Dr. Campbell: Thank you for writing this book and expressing so eloquently what many of us know is going on and would like to communicate. So, thank you.

[music]

I want to thank Dr. Michael Saag for taking the time to talk to us about his book, *Positive: One Doctor's Personal Encounters with Death, Life, and the US Healthcare System*. I want to encourage everyone to buy and read his book. You can buy it directly from the website, positivethebook.com. If you buy it there, all the proceeds will go to the [Mary Fisher Care Fund](#), which helps support AIDS research at UAB.

Before I get to the important announcement I promised, I want to remind you that you can get complete show notes and free episode transcripts at booksandideas.com. You can leave feedback on our fan pages on [Facebook](#) and [Google+](#), or send me email at docartemis@gmail.com. I'm particularly interested in hearing from listeners outside the United States about your healthcare experiences.

Also, I want to mention that I will be a speaker at [The Amazing Meeting](#) in July in Las Vegas. If you plan to attend, be sure to let me know so we can get together.

For those of you who are interested in learning more about podcasting, I want to mention that there's a new event being held in Dallas, Texas, August 16th and 17th. It's called the Podcast Movement. And unlike the [New Media Expo](#), the sole focus is podcasting. There will be opportunities to learn more about podcasting and to connect with a wide variety of podcasters. I am not speaking at this event, but I do plan to attend. You can learn more at podcastmovement.com.

Finally, I need to make an announcement of a more personal nature. Shortly after I recorded this interview with Dr. Saag, I was offered a fellowship at UAB in [palliative care medicine](#). I'm very pleased to announce that I will begin this position in July, 2014.

I was actually expecting to start this one-year fellowship next summer, but they had an unexpected opening. This means I have less than two months to prepare for some drastic changes in my life. I'm excited about moving from emergency medicine to the next phase of my medical career, and I'll tell you a little bit more about this next month. But right now I'm not sure how it's going to impact my podcasting schedule.

I do intend to post another episode of [Books and Ideas](#) next month. It will be an interview with Dr. John Ratey about his new book, *Go Wild*, which is scheduled to come out in early June. Dr. Ratey is best known for his book, [Spark](#), which is about how exercise benefits our brains. He has [been on](#) the *Brain Science Podcast* a couple of times, but this will be his first appearance on *Books and Ideas*.

I intend to cross-post this interview in the [Brain Science Podcast](#) feed, because he is one of the most popular guests that I've ever had. This month's episode of the *Brain Science Podcast* will come out during the last week of May.

Please do remember to send me your feedback at docartemis@gmail.com. You can also follow me on [Twitter](#), where I am Doc Artemis.

Thanks again for listening. I look forward to talking with you again soon.

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The music for this episode is "The Open Door," by Beatnik Turtle. Please visit their website at beatnikturtle.com.

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