If I may start with a single slight correction to the introduction for which was very generous and I am grateful. I considered graduating from the University of Chicago the high point of my career of which I am immensely proud. I cannot imagine anything up from there. Although I am also proud of the fact that I was chairman of the department of psychiatry at Cornell University, a great one, I will argue for 17 years. That is to say I am usually proud of that. I am humbled by only two things that make me careful. One is it is very hard to be proud of having chaired a department of psychiatry for 17 years when I have the privilege of giving the first Waggoner lecture who at 17 years was halfway through his career as chairman of the department of psychiatry at the University of Michigan.

The other is, it is awesome to think about when Dr. Waggoner was chair the major task of academic psychiatry was to train physicians to do what we knew how to do. That was based on the assumption that the rule of mental health care next year would be fairly similar to what it was last year. That assumption is no longer valid and the task of chairman today, including new chairmen, is to figure out what is about to happen but has not happened yet and then give his faculty, who have no familiarity with that task, an educational program for students who entered the profession expecting
something else in the entirety to confront them and to do all of this while balancing his budget, maintaining faculty morale, and operating an academic institution.

Well, probably the good sign of my wisdom is that I left the chair of the department of psychiatry in 1991 to become the dean where, as you are familiar with, my job description consists of not attending a lecture such as this one because I’m negotiating with the director at my hospital about the budget. This is not a more gratifying task than the former one but it’s a more pressing one most of the time.

When times are tranquil, discussions of medical ethics can be quite dull. Most of us tend to trust our gut sense about what is right and what is wrong. And in a stable world with adequate resources, this visceral morality is pretty good at allowing us to differentiate the good guys from the bad ones. Morals are different from ethics. Morals are rules for deciding who is good and who is bad. Ethics is the branch of philosophic discourse that informs us how to think about and discuss moral issues, how to consider and articulate the principles, the arguments, and the language of moral discourse. If you’re sure what is right and wrong, you do not need ethics. If you cannot figure out what is right and wrong and you have to think about it, you have got to have rules for thinking and that is where ethics helps.
I believe it’s the American humorist Mark Twain who captured the essence of this distinction most succinctly many years ago. Twain said, “To be good is noble. But to teach others how to be good is nobler and less trouble.” It is this critical distinction between the moralist who does good and the ethicist who knows how to talk about it that will inform the beginning of my discussion today.

A few decades ago we thought the big problem facing medicine was that we didn't know enough. We thought when scientific advances finally taught us how to cure cancer or heart disease or schizophrenia we would not have much need to worry about subtle questions of medical ethics. We might still have moral concerns. We still have to identify the bad guys and kick them out of the profession. But you don’t have to have a PhD in philosophy to do that. Our problem, we thought, was to develop the resources essential to scientific progress and to use them. At most, perhaps ethics would be a distraction to concern while the science was doing its job. Until we knew how to cure those diseases, we would have to worry about what to do when we were only halfway. We recognized that we might be too poor to move as rapidly as we wanted to.

But it never even occurred to us that we might not be good enough to make the right choices or the right decisions when we got there.
Today things look quite different.

It is beginning to look like the more we know, the bigger our dilemmas and the greater our ethical problems. Who is going to get a heart or bone marrow transplant and who is not? What do we do with the information we get from prenatal genetic diagnosis? Who deserves to know and who should not? Or for that matter, with an HIV test. A case that has occupied my home, New York City, for the last ten days, how long do you support the beloved body of a brain dead child who’s religious parents don’t want to pull the plug. A question that is complicated in this case by the fact that their district attorney believes the child died of child abuse and the corpse, now on life support, is vital evidence in the case and the corpse cannot be investigated until the plug is pulled. This is a complicated and interesting problem that involves hundreds of thousands of dollars of social resources, ethical, religious, medical problems. What do you do? Somehow our visceral signals aren’t always clear anymore. Furthermore, although we always knew and still believe that we’re the good guys, even that is now being questioned.

Some members of the public believe that we, by practicing the very highest quality of clinical medicine, are wasting valuable social resources, misallocating what should be applied to support public health preventive medicine and adequate minimal care for the underserved. They even suggest that we are motivated in our doing this by personal gain rather than
by professional standards. Our moral intuition may be less clear than it was before, but the public’s moral intuition is getting down right scary to some of us. Perhaps it would be a good idea to get some of those ethicists in to help in the dialogue.

Now most of our ethical principles have been around for millennia. However, each new historical period, each new practical situation, each new advance in medical knowledge or in medical care raises new ethical problems. Some of these test, strain, and occasionally though infrequently destroy the ancient principles that we have honored and help to generate new ones. Most often those principles survive and help us to understand and cope with our new problems, drawing on the wisdom we’ve accumulated by coping with the old problems.

I am going to talk about a new challenge, the coming revolution in the healthcare system. I am not sure. I think the title for this paper in New York is, “The Coming Revolution in the Healthcare System.” In Ann Arbor, it may be that the title should be, “The Current Revolution in the Healthcare System

There are two major themes in medical ethics in general. The first of these focuses on what is most familiar, the doctor patient relationship, clinical ethics. This discusses issues such as confidentiality, informed consent, the physician’s obligation to maintain clinical competence, to serve the patient’s
interest and it’s fiduciary relationship with the patient to advocates for the patient’s need and not to exploit the patient for any of the physician’s interests or lusts or desires. These are the issues that most people think of when they think of medical ethics. These are the ones that the public associates and the profession with the oath of Hippocrates.

The second theme of issues in medical ethics relates to medicine as a profession. An organized group of individuals who are in possession of socially valuable knowledge and skills, and therefore, who are granted considerable autonomy and privilege and authority by society ranging from being able to park your car where no one else can to performing assault and battery in an emergency without permission on an unconscious person because you believe it to be in that person’s good and to be praised rather than damned for doing both of those things. The reason we get those privileges is because society believes it is in society’s interest to give us those privileges. If the first theme of medical ethics, clinical ethics has to do with the doctor/patient relationship, the second theme has to do with the profession/society relationship. It includes the profession’s obligation to educate new members. That doesn’t grow out of the doctor/patient relationship but of our obligation to future potential patients who must also have care. The profession’s obligation to develop new knowledge, to assure access to its service by those who need those services, to advise society
about the allocation of scarce resources, to ensure the integrity and the competence of its members and to educate the public at large.

I’m going to today discuss the coming changes in the healthcare system, the challenges they present to our traditional principles of both clinical and professional ethics, some early thoughts about how we might cope with these challenges, what we might learn from them, and in passing, what I’m scared of. What justifies the word crisis in the title of my talk.

But first, let me talk a little bit about what changes we are anticipating in the healthcare system. What is going to happen, what has happened already, and what’s likely to follow. I’m certain, particularly since arriving here last night, that you and Ann Arbor are at least as familiar with these issues as I am or the citizens of any other large academic medical center. Indeed, based on some of your recent publications in the New England Journal, you are more familiar with some of these issues than most and you have actually done some of the arithmetic, which is better left undone as far as I’m concerned. I’m thoroughly in agreement with those consultation liaison psychiatrists who have pointed out that denial is not always a pathological mechanism and some things are better not known.

I’m going to describe these changes as I see them from a very particular perspective. Not from the perspective of healthcare or the efficiency of the system or economics, but rather in terms of their implications for the clinical
and professional ethical issues I have talked about. I suspect none of them will be new to you so I’m simply going to recast them in new language to help us think about them from this perspective.

First, healthcare has always been a cottage industry in this country where a single health professional or maybe a very small group of them took care of a small group of patients without much regard for the system. We didn’t think about the healthcare system. We thought about doctors and patients. Furthermore, woefully, except for a couple of visionary academics or political leaders, nobody cared much about citizens who were not patients. They were not part of the issue as we framed it. We are shifting to where there will be large organized groups composed of many different types of health professionals, para professionals, administrators and staff who care for huge groups of patients. And increasingly, not only care for those patients but accept responsibility for entire segments of the community, including both patients and potential patients. The current jargon is covered lives.

I’m the head of a faculty practice plan of about 500 full time positions in my medical school. I think it is about the same size as yours, roughly. A decade ago, I was one of the largest organized groups of physicians in my community. We’re rapidly terrified that we are so small that we may be edged out of the marketplace unless we affiliate with, combine, merge, or something else with even larger groups of physicians of somewhat dubious
quality that cover sheers of our market. I would not tell you this secret of mine except that I know you already know it because it is your secret too.

A second change, we are shifting from viewing our clients as being equivalent to our patients, to viewing them as all members of the community. Current patients, past patients, and potential future patients. We have had a clinical ethics of the doctor/patient relationship but I’ve never seen anyone even discuss the clinical ethics of the doctor covered life relationship. How do we think about that one?

It is only in the last few years in our country that the average physician became either an employee or a member of a group rather than a solo practitioner. But that rate of change is accelerating so rapidly that my medical students and residents do not anticipate ever being solo practitioners in their careers.

The daily social world of the physician has always been a world that included contact with peers and staff, as well as patients. But the social organization of the new emerging system, as viewed by an anthropologist, is a little scary. There is a corporate structure in which the patients are customers and in which the casual social relationships of the caretakers are with administrators and with each other with the patients passing through as customers do in a large enterprise. This changes the feeling of what is going on with some good but a lot of concern.
If one shift is the shift from cottage industry to organized system and another from the patient as client to every citizen in the community as client, a third shift involves not organizational structure or the definition of the client, but rather power. Doctors used to have all the power. Some of us think of that as the good old days. We decided what to do, who to do it to, how much to tell them about it before we did it to them, and then we did it. We did it because we knew it was in their best interest. Now for some years we’ve been forced to share this power with patients. We have been taught, and more or less believe but anyway accept the inevitability, that patients have a right to decide what should be done to them and their bodies and their lives. The doctrines of informed consent and the right to refuse treatment reflect this change. You know, I’m immensely proud of the fact that the doctrine of informed consent was first formulated in a law case involving the New York Hospital in 1912 or 13. What I don’t always add when I mention that is we were losers in that case and the doctrine was established in order to not let us do what we had customarily done before that, which was not bothering with informed consent. So we play a critical role in the history of this particular ethical principle. We were the devil.

The patient’s autonomy has come to be recognized as more important, more ethically valued than the doctor’s. But now both of us are losing our autonomy to external organizations, manage care companies, third parties, fourth parties, regulators, committees, and those who write and formulate
clinical pathway guidelines. Decisions that used to be made badly--I don’t mean poor decisions. I mean ethically offensively by the doctor alone then were made in consultation with the patient, then were made by the patient with the advice of the physician, are now being made by some anonymous person who will graduated high school who is at the end of an 800 phone line number in another state in front of a computer screen and who tells the physician what the decision is. And the autonomous, free discussion between physician and patient and the consensus they reach has less determining force in what happens than the decision made by this other person at the end of the 800 number. This is a serious change in where power has been placed in the system.

So one change is the shift from cottage to industrial organization. A second from patient client, the community citizen is client. A third from physician and patient autonomy to corporate control of medical practice. A fourth shift involves the economic context of the doctor/patient relationship. For centuries we’ve been accustomed to a system in which the physician might be tempted to advise and deliver excessive treatment for personal gain. This was a risk that was formulated as clearly as ever by George Bernard Shaw in The Doctor’s Dilemma that pointed out the absurdity of paying a doctor to treat you when you were sick and not when you were well, thereby motivating him to keep you sick. Shaw saw the problem and favored capitation as a solution.
We are moving toward a system in which the physician may be encouraged to under treat by the so called delivery system, which is either the physician’s employer or the patient’s insurer or both. On the surface to an ethicist, these seem to be symmetrical risks. In either case, there is a conflict of interest in which monetary gain may lead to an erroneous decision, either too much or too little. But they don’t feel symmetrical to practicing doctors. Why is that? The least charitable explanation would be that this only reflects the greater economic concerns of contemporary physicians today, their dismay at the reduction in their perceived future incomes, and their displacement of this unhappiness to a negative view of the structure of the system that’s failing to reward them appropriately. They are really mad, not about the structure, but about the fact that they are making less money and they find the structure an easy thing to blame it upon.

But perhaps there are other factors as well. The old system allowed the doctor and the patient to feel like allies. The new one can lead them to cross purposes and direct conflict. With the patient seeking the treatment that although the doctor may believe to be desirable is one that, “Isn’t covered by the plan,” or, “Isn’t part of the contract,” and one where the doctor either chooses not to or is contractually prevented from describing to the patient as an alternative.

One of the early ethical issues being confronted in the new system is where the doctor’s primary loyalty should fall in such a situation. Does he tell the
patient what he really thinks or does he defend the company line? Or let me rephrase that very biased phrasing. Does he accept the wisdom of his peers in their collective judgment about the optimal clinical pathway or does he advocate his personal and perhaps idiosyncratic treatment plan in spite of its rejection by the collective? I think most physicians’ attitudes between those two ways of describing that situation would be heavily colored by who the peers happen to be. Were they respected colleagues or expert in the field? Or were they accountants trying to optimize or maximize the bottom line of a for-profit corporation. Somehow that seems to be different.

This may be where the old system and the new one are no longer symmetrical. We are certainly accustomed in medicine to individuals who are motivated by profit. But we are accustomed to they’re being ashamed of that. We’ve never before had large powerful organizations that were proudly announcing their success in maximizing their profit while delivering healthcare, that had profit as their dominant or primary motive as their responsibility to their stockholders. This is new and this may make a difference.

There are other changes underway in our healthcare system. But for the moment, let me stop with these four basic ones that I have described already. From cottage industry to large, organized system, from patient to covered life, from autonomous to physician, to a physician who is a subordinate, perhaps an employee and from a subtle financial incentive, for the selfless
physician to over treat to an explicit financial incentive for the dutiful physician to under treat. Again, there are more, but if those don’t remind you of what is happening in recent years, you are in the wrong room, I suspect.

What will be the impact of these new developments in the healthcare system on our medical ethics? I’m going to talk about five different types of impact. And it’s a very simple-minded set of five.

First, there are some really good impacts and I believe as a profession, we should be the first to recognize them, applaud them, and point out to the public how valuable they are. For example, one of our professional responsibilities is to maintain the competence of ourselves and assure the competence of other members of our profession. On the whole, we have done a lousy job at that. Our guild concern with protecting other members of our profession has led us often to conceal their incompetence from the public and our willingness to impose on their voluntary participation has generally led us to make competence enhancing activities totally voluntary rather than required. It was only in the last few years, in the year that I was president of the American Board of Psychiatry that we reluctantly were forced by public pressure to require time limited certification of psychiatrists. You now can only be certified for ten years and then you have to get recertified. When I was certified, I was certified for life and it seemed to be perfectly reasonable from the point of view of profession that at the
age of 26 I could pass an exam meant that at age 76 I could practice psychiatry with any willing subject because I was certified as an expert in the field that had probably moved beyond anything I knew by that time. That is not right. We allowed it and the new system won’t allow it. We should probably applaud the new system for getting us to do what we failed to do well.

We have not been super at monitoring the most egregious, unacceptable, immoral, or financially wasteful behavior by members of our profession and the new system is extremely good at smoking that out and doing something about it. And we should recognize that. There are some good things.

Second, there are some bad things, some clearly unacceptable intrusions on the ethical core of the doctor/patient relationship by some of the changes that are going on in managed care. For example, confidentiality has been a core value of our profession, certainly going back to the oath of Hippocrates. There are legitimate things that it is reasonable for a payer, a third party or a fourth party to know. But they are far fewer than the information they request. Furthermore, the consent to procedures that are used are so patently coerced as to be ethically offensive. No human rights review committee for a research protocol would accept a consent form signed with the same contingencies that we casually accept consent forms for disclosing clinical information to payer. If it is not acceptable for consent for one activity, it is probably not acceptable for consent for the other activity. The profession
has a responsibility to define the appropriate limits by which others can intrude in the doctor/patient relationship and then to defend that boundary ferociously. We have not done that well.

Secondly, the new system has challenged the physician’s primary fiduciary responsibility to concern for what is in the patient’s best interest. In an at least one dramatic set of cases has explicitly stated that the physician’s employee relationship takes precedent over that fiduciary interest. I’m talking about the so called gag rules that have been included in a number of managed care contracts in which the physician provider is not allowed to tell the patient anything that is inconsistent with the position of the managed care corporation on the delivery of that specific area of healthcare. I believe that any physician who signs such a contract is doing something unethical. Even if he doesn’t go on to do it, to agree to it is unethical. And I think our profession should make that so explicit that you get brought up on charges if you do that just as much as if you spoke out about a secret you learned in the clinical relationship or if you violated a patient’s body for your personal amusement rather than for the patient’s welfare. Those are all violations of our core contract with what we’re doing here, and I think we have immense power. I think if we announce that this contract is unethical if a doctor signs it, those companies would back off awful fast. A recent brief article in the New England Journal of Medicine about such a contract forced one of the biggest HMO’s in the United States to reverse itself, announcing that it was
clarifying its contract and totally reversing it in the process. I don’t know if you have a lot of U.S. Healthcare business around here, but it was U.S. Healthcare. I think we haven’t taken a stand where we have to on that.

Thirdly, everyone agrees that one of the potential powers of the new system is to monitor, assure, and enhance the quality of healthcare. But not everyone agrees on what the definition of quality is. To a large organization selling healthcare, the definition of quality is what customers want. To a profession, the definition of quality is what patients need. And we’re not so good at educating the public that they want what they need. Therefore there is a gap between the organizations that sell healthcare who define quality in terms of the attractiveness of the waiting room, the length of time before your phone call is answered, and the pleasantness of the relationship with the provider but aren’t as concerned as we are about markers of the quality of the care that’s delivered in terms of the biomedical sophistication, particularly if it is care that is involved in ruling out, diagnosing, or assessing rather than delivering treatment. I do not know how to initiate a psychiatric treatment plan within 24 hours of meeting most people I have never met before. I have had many years in the field. I am a clinician more than a researcher, and I do not know how to do it. But there are a lot of contracts that force one to do it. I think we have to talk about that.

In the old days, physicians defined quality. Recently in the political process, we have moved to public definitions of what is priority, what is most
important, which is one part of quality. You have seen that in the fascinating Oregon experiment with having a priority list of what is most and what is least important in healthcare defined by a public organization in a democratic dialogue. One of the first decisions they reached, one dear to my heart, is to exclude mental healthcare from healthcare in that process, and the courts forced them to back down and reverse themselves on that one. But the new system is not primarily interested in either the democratic dialogue or the profession’s views. They are interested in the market’s views of quality. The market does not value public health as much as personal healthcare so it is far more concerned about the ready availability of a useless visit with a doctor than with the use of the same resources for public health interventions in which the client will benefit but will not be aware that anything happened. It is much easier to get public support for readily available house calls than for inoculations for measles. But ask anyone what the relative cost-effectiveness of those two procedures is who knows the data.

So as we move from physician based quality to public based quality to market based quality, we move toward anti-public health, pro-user friendly, anti-access for the underserved, a very special package that professionals ought to be uncomfortable with. I’ve talked about some ways in which I think the system is potentially good and others, perhaps more in which it is potentially bad. But frankly I think both of these are fairly self-evident.
And I want to close by going into some areas where I think it’s neither good nor bad and where it is not quite so obvious.

First, of special interest to people in this medical center or mine is there are a number of areas in which the new healthcare has decided it is irrelevant, but we as a profession are not irrelevant and we have to think about those and not let them fall off our plate. The most obvious ones are the profession’s responsibility for educating new members of the profession and for creating and generating new knowledge. That is not a concern of organizations delivery healthcare, but it is a concern of a group of physician or experts on health and who are supposed to advise and counsel the public on what to do in this area. The resources that support our educational and research enterprises have long been stolen or borrowed from a hugely inefficient, highly lucrative healthcare system. As we make that system efficient and streamlined and cost accounted, that source of stolen resources will no longer be available. That is already happening in places such as this. Either we have to educate the public and help them generate new resources for us or we have to downsize our system, or both. Or we have to recognize that we are going to have a very, very good healthcare system for ten or fifteen years and then no system at all.

Some of the planning has about a ten year window. The original Clinton set of task forces on the future of healthcare included 42 committees, none of which were interested in academics. We added one three months later on
academic medical centers. So the public needs help in research and education. The profession is concerned with help in research and education, and we are not assured that the major providers of healthcare in the new system share that concern as did the less efficient but more socially minded providers of healthcare in the old system, the great non-for-profit community based hospitals with boards of directors who were concerned with what is good for the community rather than with their bottom lines.

If our major academic centers become links of highly efficient provider organizations which compete in the market and medical schools that survive off of their tuition, we will see a dramatic demise in the quality and value of those academic institutions for our nation. This is a scary and not totally impossible prospect confronting us at this time.

In addition to education and research, although our public governmental leaders have had some interest in assuring access for the underserved, it does not seem to be an important priority for corporate healthcare in general. Another type of access, access that involves the continuity of care, access to the same doctor one had last year this year, particularly important for chronic patients and for a special group of chronic patients that I have an interest in, the mentally ill, that type of access is also not defended by the new system. In a commercial model with customers, you can change providers at will. There is no value added in the mind of the organization
providing the care to having a continuity of the provider/customer relationship.

Fourthly, the new healthcare system, as I’ve said before, is probably a very good ally in ensuring the competence and continued growth of competence of those who are working within it. It has little interest, and perhaps negative interest, of competence of those who are not working within it. Therefore, we have seen the growth of proprietary attitudes toward advances in scientific knowledge relevant to healthcare, companies keeping secrets about new drugs or new treatments so it will have commercial advantages over their competitors. This is not exactly what most of us thought was core to the Hippocratic medical ethical tradition. The profession has a responsibility to ensure not only the competence of all the providers in the specific healthcare system in which the individual himself belongs but all the providers in the profession whatsoever. It is part of our core definition, and we do not have good ways of doing that.

And I have talked about what is good, what is bad, what is left out, and we have to attend to because it is irrelevant to the new system, but we are in danger of being so distracted by the new system that we do not spend time attending to issues that it leaves outside of its purview. I believe that one of our major responsibilities as a profession, part of the professional ethics rather than clinical ethics, though we’ve only begun to recognize is if healthcare is going to be delivered by large, often for-profit organizations
led by administrators and business people and financial people, then we have a major responsibility for advising the public on how to cope with such organizations, for helping governments write the regulatory rules, for insisting that just as it was prudent for a community hospital to have businessmen rather than doctors on its board 30 years ago or it would go bankrupt, it is prudent for the government to require that they are real doctors as well as businessmen on the board of any organization that delivers healthcare to assure that it will not only not go bankrupt but will also take care of its patients. I cannot imagine any valid reason for not requiring professional caretakers in governance roles in any organization that is going to be chartered to give professional care. But we do not now have those requirements.

Advising the government re-regulations is one of our obligations as the advocates for health concerns in our community regardless of who is providing the healthcare and who is making or not making money in the process of doing it. So I have talked about good things, bad things, things left off the plate, new charges for the profession’s ethics, and I will have one other new charge.

Medical ethics has been the ethics of doctors and other health professionals. But we need a new kind of ethics that we have never needed before, an ethics of organizations. If organizations are going to have the power to make decisions that affect people’s lives, then we have to have codes of
conduct for organizations and teeth attached to those codes. An organization that comes into a community and develops a healthcare system that wins out over all of its competition cannot then close and leave the community with no care at all. That is offensive, but that has happened. And our regulations and rules have allowed it to happen. It is different if you are selling healthcare or automobiles in a community. It is okay if the only automobile agency closes but not okay if the only doctor closes. An organization that owns the only gamma knife in town cannot use it to care for its patients and not others in order to have a market advantage in that town without offending something that is core to our culture. So we need a way of thinking through that so there will be organizational ethics as well as individual professional ethics if organizations are going to be allowed to play in this field. And they are being allowed to play in the field.

I believe that we have great power that we have not used because of our professional credibility with the public. We are in danger of losing it if we appear to be too clearly a guild interested in advancing our own welfare. But if we maintain reasonably concerned with the values of the public in receiving healthcare and in maintaining the quality of our relationship with them, they will be immensely interested in the profession’s score cards on which providers follow the rules and which ones don’t, which ones adhere to ethical standards for healthcare organizations and which ones don’t, and if we do a kind of good housekeeping or consumer’s report evaluation of the
various organizations in the market, we will give immense market advantage to those who play by our rules. I think it is vital that we figure out a way to do that.

What are the rules we must, at all costs, preserve? I would say that I cannot imagine a profession that deserves the name of medicine that allows doctors to keep secrets from patients for other than the patient’s benefit. I would say one rule is nothing can interfere with the--I wouldn’t trust a doctor who I thought had a motive to keep a secret from me because of a contract with his employer. And I would not entrust anyone to trust me in that situation. We cannot allow that.

Secondly, we need something equivalent to academic freedom that protects physicians who advocate for their patients needs from retaliation from the organization in which they are working. The doctor should have no constraint and should be protected legally from any constraint on his ability to fight for getting the patient what he thinks the patient should deserve. I am not saying he should always get it. Doctors, as any advocate, may be misguided and may be making poor scarce resource allocation decisions. But they should never be told to shut up and not pursue what they believe to be their patient’s interest.

Thirdly, I think the profession has to be very clear on delineating what are the limits of the kinds of situations in which we are willing to work. What is
too evil for a physician to participate in? Let me give you some examples from our history. The psychiatry profession decided that, a decade or two back, that there were totalitarian governments that were asking psychiatrists to play roles that were not professionally acceptable. You could not be a good doctor working in a totalitarian country where your job was to suppress descent rather than treat illness. And we ran out of the profession leading practitioners in those countries who didn’t accept that.

Let me tell you an anecdote. We at Cornell, as I suspect you do at Michigan, have a course in medical ethics for second year medical students and we presented a case seminar two years ago in which we had a panel discussing a case with a class of 100 second year students and it was a simple and interesting case. It was a man who came to see a generalist physician in our clinic, a real case, who had been transferred there because he had just--his employer had switched contracts with HMO’s and the new HMO had a contract with our clinic. And he had a cough and a little hemoptysis which he’d had for several months and he was a little worried about it. He was a chronic smoker. He knew what it might be. He hoped it was not that and he told the doctor that he wanted to have a checkup and he also told the doctor that if it was cancer, he had thought about it and he was going to kill himself. He came with his wife to the appointment. The clinician arranged in our system to get a quick x-ray and went to look at a wet reading and saw at least what was on wet reading an unequivocal neo-plastic diagnosis. That
was the case. And we talked about a number of fascinating ethical issues. We asked the student, “What are the issues?”

We talked about the patient’s right to know. We talked about the ethics of suicide and the doctor’s potential role in suicide. We talked about the confidentiality and whether the wife who was in the waiting room should be called in and involved in this before or after or during exposing it to the husband. We talked about questions of competence and the fact that we had a wet reading by a primary care doctor. Did he have an obligation to talk to a radiologist first before basing his judgment on his less than state of the art knowledge of how to read that film. And I was the last one to speak and I chose not to do what I was supposed to do. I was playing psychiatrist that day rather than dean, but I chose to play dean rather than psychiatrist and I said, “Did anyone worry about whether the guy who makes our contracts with managed care companies should have agreed to sign a contract in which he was forced to switch doctors last month? This was a man who had seen his physician recently for the same symptom, had a good relationship from that physician and was told, ‘You are no longer being cared for by this person in this clinic but by that person in that clinic.’ And we signed that contract. Was I ethical in putting my signature on that document and accepting a bad pattern of healthcare so that I can increase my market share a little bit and my bottom line that year?”
The students were nervous with that dialogue, but not nearly as nervous as my faculty. Nor as I that night at home when I thought over the case. So I think we have to outline what the rules are that we are willing to play by and be a little less passive in accepting rules that have been imposed by the market upon us.

Fourthly, I have talked about full disclosure. I have talked about freedom for advocacy. I have talked about the separation of our clinical--I’m sorry, I have talked about the limit of our participation in evil. A fourth one is the clear separation of clinical and administrative roles. I think it is perfectly reasonable for physicians to function as reviewers and refusers of treatment but not for their own patients. I think the patient has a right to know my doctor is my doctor and if my treatment plan is rejected, it was rejected by some other guy, not by the guy who is taking care of me. That no one is ever in the position of deciding not to do what he thinks is best because he is worrying about covered lives rather than about his patient. There are many who would take a sharp public health difference of view with me on this, but my argument in response to them is, “If you had two doctors who were honest with you, one of whom was simultaneously monitoring the use of resources while caring for you and the other one was totally working for you and only someone outside was monitoring resources, which one would you continue to see after your first visit?” I have yet to find someone whose attitude toward the value of public health was such that he would rather see
the doctor who was a resource monitor rather than the doctor who was a personal advocate for the patient.

Fifthly, I think we have to systematize the profession’s ability to cope with these new strategies. We have to strengthen our professional organization, improve our communication to the public to protect the value of our core principles of clinical ethics. We have to greatly strengthen our professional ethical activities. Medicine has come out of a period of half a century in which there was a love affair between medicine and the public and we could comfortably sleep without much concern for the public’s regard for us and protection of us. That is over. And we now have to struggle to protect our values and that requires the effort of members of the profession.

I think that medicine will survive and will outlive the current revolution in the healthcare system and the next one and the one after that. I believe healthcare executives will, when they get sick, come to our ICUs and we will take care of them there, both in this system and probably after it is over. But I think it is important that in doing that, we preserve and enhance our core ethical values that go back to a second theme in the Hippocratic Oath. I talked about the most famous theme, the obligation of the physician to the patient, not to do harm, to call in consultation, to maintain confidentiality, the obligations we all know so well. But a second theme in that oath is the professional ethical theme.
The Hippocratic physicians succeeded in a market competition. They were one of a number of groups of physicians in the ancient world more than 2000 years ago. They were composed of a group of itinerant practitioners who went around from town to town, set up a booth in the marketplace and cared for patients. Not too different from a modern managed care system. If you read the oath, they have to be good doctors not so much because it’s patient ethics stuff but because it is a good marketing strategy. What they learned is that the other doctors, the non-Hippocratic ones, would seduce the slaves, would sell poisons, they would do all kinds of other things that meant when the next one came to town instead of trusting them, all the citizens ran the other way. The Hippocratic docs figured out that if we are honest, ethical doctors, then even if we have never met them before, if we wear that logo on our jacket, when we show up in town and we tell them we are Hippocratic, they will know we are sworn not to do those things. And the oath tells you that if you break the oath, the punishment is that you are kicked out of the club. You also swear to train others to do it your way. We have to make medicine a profession where once again, the public knows that we do not do bad things no matter what the reward is, that we do good things because that is the way we have been socialized to practice, and that those core values are more important than our employee/employer relationship.

Ironically in 1996, as in 400 B.C., nothing will enhance our value in the market more than our being perceived as placing our ethical values above all
else. So I appeal not on ethical grounds, but on shrewd entrepreneurial grounds that we reaffirm our core values in medical ethics. Thank you.