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“Fixing Health Care the Ethical Way.”

Well thank you so much to both of the introductions. It is a real pleasure, an honor, and a privilege to be here at the University of Michigan. I actually haven’t been up here since I was in college down in Northwestern and came up here to play the Wolverines.

I am both humbled and honored to speak to you on this wonderful Waggoner lectureship. And as you’ve already heard Dr. Waggoner was a great teacher, a great psychiatrist, and a great man, and whether as an administrator or as president of the APA he was a true visionary. He was also the consummate optimist and a strong believer that with the right ethics and values physicians could accomplish great things.

Today I want to talk about ethics in the context of our evolving healthcare system. With so many challenges and so many changes taking place how can physicians ensure that our core obligations are upheld? And how can we, like Dr. Waggoner before us, bring both the human and the humane to our healthcare system? How can we fix healthcare the ethical way?
Now let me start by taking a step back and looking at the big pictures. Scholars have weighed in on the topic of ethics for centuries. “We do not act rightly because we have virtue or excellence but we rather have those because we have acted rightly,” Aristotle. “Man without ethics is a wild beast loosed upon this world,” Albert Camus. “Relativity applies to physics, not ethics,” Einstein. Now all three of these quotes testify to the need for an agreed upon set of principles governing behavior, a code that separates man from beast. And this code serves for all of us as a moral compass when we make decisions. And we are relying on it not only in our personal lives but certainly in our professional lives as well.

Of course in certain professions, especially in medicine where life and death are at stake and perhaps that’s why we at the AMA have such a rich legacy in ethics dating back originally to Hippocratic Oath. And then in 1847 the AMA built on that foundation by publishing the first code of medical ethics in the country. We detailed the obligations of physicians to their patients, to their colleagues, and society and we’ve been updating that code ever since. And for those of you psychiatrists in the room you may remember that the APA’s code was first published around 1972. It had annotations, especially applicable to psychiatry.

If we were to summarize that code as it stands today we could use the words of Georgetown University professor, physician Edmond Telegrino. He says, “Our charge as physicians is to work with patients to arrive at a right
and good healing decision.” And in order to do that we have to keep six core commitments in mind. First to put patients’ interests above our own, to be compassionate and candid, to help patients understand their medical situation and treatment option so they can make informed decisions, to seek to understand each patient’s values and goals for healthcare, to work with patients to develop treatment plans that align with those goals and values, and respect the autonomy of patients to make decisions.

Now in the past the majority of ethical questions in medicine have revolved around the bedside, whether it’s physician assisted suicide or palliative sedation. And while many of these challenges still persist today we’re also faced with a new set of ethical challenges, challenges that involve not just our relationship to the individual patient but to the larger healthcare system as a whole.

Now we’ve got lots of difficulties in this country. One is we’ve got soaring healthcare costs. As this chart shows our healthcare costs are generally at least double and in some cases even triple those of our first world counterparts. We spend more than two trillion each year on healthcare. And that comes to almost 18 percent of our GDP or 7,681 dollars for every single man, woman, and child in this country.

So where’s all the money going? Well 448 billion dollars is going to treat patients with heart disease and stroke. One hundred seventy four billion to
treat patients with diabetes and the list goes on as you can see up there on the slide. And today a full 75 percent of healthcare spending can be attributed to a second major challenge for our healthcare system, the epidemic of chronic conditions.

So more than two thirds of adults and almost one third of children are either overweight or obese. The number of Americans with diabetes has tripled since 1980 with 18 million diagnosed cases and another seven million undiagnosed cases. Every 40 seconds someone in the United States has a stroke which is the leading cause of long term disability. And the American Cancer Society estimates that 1.6 million new cancer cases will happen in 2012 alone. So the fact is that there’s an epidemic of chronic conditions sweeping this country and caring for patients with complex, long term illnesses is costing us more than a trillion dollars every year.

Now on top of these problems there are of course numerous other challenges that we all face. The lack of access to insurance which forces millions to neglect their health until a worst case scenario and sends millions more to the emergency room for services that could have better been provided at a doctor’s office. We have a fragmented and disjointed delivery system where physicians, nurses, hospitals, and nursing homes basically operate independently rather than in some coordinated effort.
Our healthcare outcomes often lag behind those of many of our first world counterparts as I mentioned and hundreds of billions of dollars is lost in administrative waste. And to add on to this are certainly the social determinants of health which I will not talk about in great detail, things like poverty, unemployment, access to healthy food, access to transportation to get to see the doctor and education. These all add to the complexity of what causes the healthcare situation we’re in right now.

Now as you know the Affordable Care Act seeks to address many of those problems and while it isn’t perfect it is a historic first step in reforming our healthcare system. And since I was told by Mrs. Margolis that she didn’t realize that the AMA supported the healthcare act, the Affordable Care Act, if you don’t know that, the AMA supports the Affordable Care Act. So if this is news to you I hope that’s good news. It might not be good news to some of you but it was good news to a lot of patients.

So what are the key provisions in the law? Well it expands coverage to 30 million Americans, about half in Medicaid, about half in private insurance. It reforms an array of insurance practices from lifetime coverage limits to pre-existing condition denials. It invests in new delivery models such as accountable care organizations, medical homes, bundled payments, other forms of payment delivery. It supports prevention and wellness efforts. It promotes quality and the use of comparative effectiveness research. It streamlines administrative processes and it invests heavily in health IT.
Now today during the third year after the ACA was passed many of these provisions are already underway and the quest to engineer a better healthcare system has begun. But how can we be sure that it’s going to be an ethical system? What commitments need to be made at the system level and what commitments need to be made at the personal level? And what is the AMA doing to help create an ethical healthcare system?

So let me begin with the system level. As physician practices, hospitals, insurance companies and other stakeholders across the country begin transitioning towards large integrated systems such as you have here at the University of Michigan there are five core ethical elements and commitments that have to guide our way. Now first we have to have open communication between physicians and patients. If managed care taught us one thing it’s that physicians should never be incentivized to withhold information from patients. And as physicians we always have to feel free to treat patients with a particular drug even if it isn’t on a health formulary or a specialist--refer to a specialist who isn’t in the plan network. But given the current pressure to reduce spending we certainly should keep costs in mind when we compare different treatment alternatives. And I’ll talk more about that in a few minutes. But ultimately all the options, not just the cheapest ones, must be communicated to patients. And for some of you who have been following the news down in Florida and the issue down there where the Florida legislature passed a law that pediatricians and family physicians
could not ask parents of kids whether they had gun, gun safety in their homes, the AMA appealed that ruling and that’s now on hold. So that was a gag clause that was initiated by unfortunately the state government.

Going on with commitments at the system level we have to make sure that an ethical system must base its guidelines for resource use on real, hard data about the practices involved. We have, for example, a family practice has a different kind of patient population than myself as a psychiatrist. And just as academic medical centers tend to see patients with more complicated conditions than the average community physician, so resource expectations have to be set accordingly. They must focus on the specific demographics and needs of the patients that they serve.

Number three, an ethical healthcare system must employ well designed incentives. It has to promote efficiency but never at the expense of patient needs. Just as physicians should not be incentivized to withhold information from patients, we shouldn’t discourage the ordering of a clinically useful diagnostic test solely because it’s expensive. And by the same token we shouldn’t be encouraged to order extra diagnostic tests just because we’ll be reimbursed for them.

In addition incentives need to be based on sound data about care and costs. They should be collected from large populations of patients and multiple physician practices. They should be over long periods of time, at least a
year instead of six months so that periods of high utilization of services are more likely to be balanced with periods of low utilization and give a more accurate picture of what the actual costs are. And they should provide ways to compensate physicians when they treat patients with unusually complex or extensive needs.

Now well designed incentives should also limit the magnitude of financial risk faced by any individual physician. The more timely an incentive ties a financial outcome to a specific treatment decision the more problematic the incentive is. And they should be implemented even handedly across all physicians participating in the organization. So for example they shouldn’t be deployed in a way that favors specialists over primary care physicians. It’s also important that incentives don’t encourage cherry picking, that they don’t disproportionately affect patients with chronic illness, complex healthcare needs or other special populations and that they don’t disadvantage physicians who care for these patients. And of course it’s crucial that incentives are developed with physician input through a mechanism analogous to a hospital medical staff or health plan pharmacy and therapeutics committee on which physicians are representative--represented.

Finally, an ethical healthcare system must allow physicians to be advocates for patients. It must build exceptions into resource utilization guidelines. It has to make it easy for physicians or their staff to appeal a denial of
coverage on a patient’s behalf and it has to be transparent, fair, and consistent in reviewing these appeals.

Now to summarize an ethically strong healthcare system or organization takes a physician’s core commitments into account and promotes their integrity as professionals. And it achieves this by supporting a physician’s focus on their patients’ welfare, their fundamental commitment as healers, by respecting the patient/physician relationship and the process of developing treatment plans that compared with the patient’s values and goals, that promote treatment recommendations that are both patient centered but also cost conscious and minimizing conflicts of interest.

Now this last point about conflicts of interest, that warrants some further examination because the fact is all models of payment and care delivery including those that we’re looking at now and experimenting with raise some conflicts of interest for physicians and systems be they financial or otherwise. For example under a fee for service system there’s a built in incentive for physicians to over-utilize healthcare resources whereas under capitation system there’s a built in incentive to under utilize resources in order to stay within a fixed rate of per member per month that’s paid for capitation.

Now that brings me back to the individual physician and what we can do to help create an ethical healthcare system. One thing we can do is to think of
ourselves as responsible and prudent stewards. That is, we can balance our commitment, our commitment to care for each individual patient with our responsibility to use common healthcare resources in a wise and prudent way. Someone once quipped and I’m sure you’ve heard it that the most expensive technology in healthcare is a doctor’s pen. And there’s certainly some wisdom in that. And for example, in 2010 Consumer Report surveyed nearly 1200 healthy 40 to 60 year old men and women with no known heart disease, risk factors, or symptoms and found that 44 percent had received screening tests for heart disease. Now obviously physician treatment recommendations aren’t the only drivers of healthcare costs as I mentioned before. But our decisions do play a significant role in healthcare costs and how we utilize the resources we have. So that’s why this past June the AMA, our house of delegates, passed ethics policy advising physicians to be prudent stewards of the resources that society entrusts to us as healers.

Clearly there is no magic bullet here when it comes to being responsible stewards. Like all ethical issues it’s complicated. And as one of my former mentors in ethics told me when asked about an ethical situation he said, “It depends.” So it is complicated. But the AMA has laid out some basic guidelines that we can keep in mind.

First we always have to ensure that treatment recommendations are based on medical need. That is, we should not order, recommend, or participate in care that does not offer reasonable likelihood of medical benefit. We need
to listen closely to what our patients and family members tell us and to understand their goals for their healthcare. We need to make sure that our treatment recommendations should always be scientifically grounded. Existing data and research should help us to assess the potential benefit of a proposed intervention. And fourth, when alternative causes of action offer similar likelihood or degree of benefit we should recommend the lower cost option. So for example, not ordering a serum pregnancy test when a less costly urine test would be just as appropriate clinically in the patient’s circumstances or using a generic SSRI instead of a name brand SSRI if we think they are equivalent. And fifth, we have to clearly explain our thinking to patients, the differences between alternatives including costs, and why we think a less costly alternative will meet their healthcare goals.

Now as you probably know the AMA is not alone in advocating this kind of cost conscious decision making. In January the American College of Physicians published an updated version of its ethics manual that advises doctors to deliver parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient. And in April the American Board of Internal Medicine Foundation unveiled a list of 45 overused tests and procedures that nine specialty societies say doctors and patients should think twice about before they order them and perform them.

So now these organizations are responding to the reality that a large percentage of healthcare being delivered today and some experts say it’s as
much as 30 percent is either duplicative or unnecessary. Now as the nation strives to reign in healthcare costs physicians can actively contribute to the solution. Another thing we need to do to support a more ethical healthcare system is to embrace a new set of values, four core values. One’s better suited to integrated and coordinated care and let me explain that a little bit more.

For years one of the values that we as physicians have cherished most is autonomy and there’s good reason for it. As Atolga Wondey put it, “The core structure of medicine, how healthcare is organized and practiced emerge in an era when doctors could hold all the key information patients needed in their heads and manage everything required themselves.” And those who trained at about the time I went through know that that’s exactly the case. We had to have all the information in our heads. We had those little black books but everything was in our heads when we needed to take care of our patients. But those were the days before insurance company hassles, medical malpractice and multiple government regulations. It was also before physician shortages, aging populations and the kind of complicated chronic conditions we have and before we had more than 6,000 drugs and 4,000 clinical procedures at our disposal. In those days it really did make sense for physicians to value things like autonomy, independence, and self sufficiency. But today those values really don’t suffice.
We have come a long, long way since the days of a doctor with a black bag holding the tools of his trade. I still got my old bag that I got from Lilly and here’s a doctor looking at an iPad viewing their medical history, coordinating the care with a team of physicians and other professionals. So whether it’s in medical homes, accountable care organizations or a system like you have here at the University of Michigan collaborative care models are the wave of the future. That is the way things are going. It doesn’t mean everything is going to go in that direction but likely going to head in that way in a more accelerated way.

Now in order for team based models to work there needs to be a shift in some of the fundamental values we have. So for example instead of autonomy we need to value teamwork to recognize that no one person can provide all the answers or all the care that a patient needs. We need to cultivate mutual trust, recognizing that each medical team member has unique skills and knowledge to help the patients that we take care of, that the general practitioner has a different set of skills to offer the Alzheimer’s patient than the neurologist or the psychiatrist who’s treating that patient’s depression or the caregiver who delivers the daily regime of medications to that patient. We have to support this trust with open and timely communication among all healthcare providers so that all members of the care team are on the same page.
We also need to admit that on rare occasions admittedly we do make mistakes. And discipline at times is necessary but a willingness to use guidelines, checklists, standard procedures can help us to avoid those problems so that hopefully we don’t end up in medical boards. And finally we have to fully commit to improving the quality of healthcare for our patients in this country. That means keeping an eye on the larger healthcare delivery system and it means collecting, sharing, and analyzing data so that we can leverage that for the care of all the patients in this country.

Now here at the University of Michigan I know that you’re already functioning in a large, integrated system. But as I travel across the country and I’ve traveled across east and west, north and south, on behalf of the AMA you would be amazed how many physicians vehemently resist this notion of collaborative care. And it’s not just that they want to maintain a private practice but the idea that I am autonomous, I still have all that information and I’m doing the best I can resonates with some physicians in this country. They think that being part of a team and following guidelines and best practices somehow robs them of their ability to think or create or to do good by their patients. And I think that in general they are wrong and a great example of the kind of creativity and impact of integrated healthcare teams can have and I talked about it a bit this morning at Grand Rounds is the South Central Foundation which is based in Anchorage. It’s run by and for Alaskan natives up there. And they have garnered national attention for
their success at reducing health disparities through a coordinated approach that they call the NUKA, N-U-K-A, system of care. And here’s how the system works.

Patients are assigned to a healthcare team. It might be, for instance, a physician, a nurse, two medical assistants, a behavioral health therapist and an administrative assistant. They’re connected to a nutritionist, pharmacist, and various specialists, sometimes even including traditional healers in their facility. And then through emails and texts physicians can keep tabs on their patients, reduce unnecessary visits to both the office and the emergency room. So today South Center serves 60,000 Native Americans with just 1400 professionals. It offers 65 programs to tackle domestic violence, suicide, obesity, substance abuse, diabetes, heart disease and a host of other issues and all delivered in the context of cultural sensitivity and understanding. Basically they built from the ground up and as a matter of fact they call their patients consumer owners. They don’t call them patients. They call them consumer owners.

But the proof really is in the numbers. So in the last decade South Central has achieved a decrease of 40 percent in ER visits, 75 percent in hospitalizations, and 30 percent in routine doctor visits. Moreover they have successfully accommodated an annual increase in the number of patients of seven percent while receiving only a two percent annual increase from the Indian Health Service. And they’ve made significant inroads in addressing
major health disparities among their population. So today up in Alaska binge drinking, strokes, heart disease, and cancer rates for Anchorage area natives are now about the same as the national average which is a major victory for this particularly demographic area of our country.

Another example of this and I spoke a bit about this this morning is the Diamond Initiative up in Minnesota. This is in an integrated care setting where it’s a Minnesota based program that helps primary care clinics more effectively care for patients with depression. And they used six key components. They used a screening tool, the PHQ9 for the diagnosis and ongoing management of depression. They do systematic tracking of their patients using that PHQ9 and they use a registry to track any changes in those PHQ scores. They use evidence based guidelines and a stepped care approach for treatment modification. They have relapse prevention planning for patients. They have a care manager who educates, coordinates care, troubleshoots for the patients and they have psychiatric consultation and case load review.

Again, the proof is in the numbers. By the beginning of 2012 more than 8,000 adult patients with major depression or dysthymia had participated in the Diamond program. The clinics reported that 30 percent of their patients with depression were in remission within six months of their initial assessment. That’s a rate that six times higher than the results reported for primary clinics statewide. The 12 month remission and response rates for
Diamond patients were at 53 percent and 70 percent respectively which shows that over the course of time they have been successful in terms of relapse prevention also. And due to the success they’ve had with depression they’re looking at expanding that to other mental illnesses as well and really to provide a foundation for the design of a very good healthcare home for the patients that those clinics take care of.

So I hope you see that from our point of view that integrated care models provide lots of room for innovation. They can achieve dramatic results in a relatively short period of time. And by incentivizing different members of the healthcare team to work together they can improve patient outcomes. They can lower healthcare costs and they can increase patient safety and satisfaction. So from an ethical point of view they make it easier for physicians to actually fulfill not only our obligation to our individual patients but also to society or the community of patients that we’re taking care of. So we can say that they create a win/win situation for everyone involved.

Now of course I’m a psychiatrist and I realize the last statement about win/win sounds a little bit optimistic but even, maybe, a little Pollyannaish. So lest you think that I’ve started playing the glad game here or self medicating, let me temper that statement with the following observation that the transition that I am talking about is very big. It is very big. It’s very complicated and it is not going to be easy. As a matter of fact it’s going to
be very difficult. No matter what’s happening with the Affordable Care Act my presumption is that it’s going to be implemented, our hope is that it’s going to implemented. We have a very long and difficult hill to climb to make that integrated notion of care actually take place across the country for those who want to do it. And that takes me to the last topic that I want to talk with you briefly about and that is the work the AMA is doing to try to tackle a number of these big, big problems. And as our new CEO Jim Adari says--calls this, these are moon shots. These are extraordinarily difficult things that have been difficult for systems, for our country to actually undertake in the past. But we think we’re going to work at trying to create an efficient, more- efficient and effective and a more equitable healthcare system.

So we recently developed a five year plan to help America’s patients and physicians actually thrive and do well in the 21st century. So our goals are threefold. First, to improve health outcomes, second to improve payment and delivery models and third to improve medical education. First let me tell you a little bit more about the health outcomes.

As I mentioned before at the beginning of this presentation today the United States spends twice and in some cases almost three times as much per capita on healthcare compared to other similar counties, Australia, Canada, Germany, and the UK. Yet when we compare the care that we deliver at--and what we have available to members of our population we’re the last or
next to last. If you can take a quick look at that slide you’ll see we’re at the bottom there on most of these measures that we have dealt, obesity, heart disease, mortality, AIDS incidents and so on. You can--if you want a slide we can get it for you. But it’s pretty clear that we are down low in all of those measures.

Now it’s not that we don’t have the capability. I mean you have the capability right here at the University of Michigan to do many of these things and I’m sure on many of these measures you do quite well. We have the foremost training and great physicians and great training but there are a number of variables, as I mentioned before, that contribute to those poor outcomes including the social and environmental determinants and accessibility to healthcare that I talked about. In addition to that medicine is becoming more and more complex, as you know. Today there are more than 13,600 diagnoses. There are 6,000 drugs and 4,000 medical procedures to keep track of. So ensuring that all the patients in this country get all the care they need at the right time and at an appropriate cost is a big and Herculean task to undertake. So as physicians we have to work to deliver the best care to our patients on an individual basis each and every day. And now at the AMA we are harnessing our resources to help our medical profession do the same collectively across the nation.

So we have already begun analyzing outcomes data and speaking to leaders in the field to identify clinical conditions that impact a large segment of the
U.S. population. Next we will develop a national dashboard on specific health topics. We’ll work with partner organizations to reduce both the disease and the cost burdens associated with them. We’ll establish national goals for improvement and facilitate the adoption of strategies that achieve the triple aim of better care, better health, and lower costs. And we’ll track our progress and tweak our strategies as necessary to ensure we’re having the biggest impact.

Now in a couple weeks I think we’ll know a couple of disease entities we’ll be taking a look at, maybe diabetes and maybe depression and maybe congestive heart failure. But I can tell you that they’re going to be the big disease entities that will have a dramatic impact hopefully on the population at large.

Next, improving payment and delivery systems and I talked about a little bit about that before. For decades both health plans and the government have attempted to reign in excessive costs, reduce fragmentation, and improve quality but to date it really hasn’t worked except in pockets around the country. So in both the public and the private sectors there is a consensus that the current system no longer meets the needs of physicians and patients in this country. Of course as physicians we know that identifying what’s broken is generally far easier than fixing it. So for example this morning I talked about the broken Medicare payment physician--payment formula, the SGR which I’m sure some of you are familiar with. We’re trying to get it
repealed but we’re also trying to find a way to replace it with something that will work better because no one has presented a formula that’s going to work better than it yet. So when it comes to fixing something as complex as healthcare delivery one size definitely doesn’t fit all because what works for organizations and physicians in Detroit is probably not going to work for physicians and organizations here in Ann Arbor.

So over the coming years at the AMA we will analyze current and emerging payment and delivery models from the physician perspective. We’ve already been partnering with a variety of physician organizations across this country. We have 25 physician organizations from small practices to middle size practices to large integrated systems like you have here at the University of Michigan. We will work with them to identify which models best provide both high quality patient care and physician satisfaction because what we hear from a lot of physicians and I talked about this a little this morning is physicians in a lot of areas of this country feel burned out. They don’t like what they’re doing. They get depressed. They’re suicidal. There’s a lot of stress in the system based on what’s going on now.

So what we want to do is present models to physicians that--so that they can pick the kind of practices that will be best for them. And for example what’s the best way for a small practice to incorporate health IT? How can a large hospital based practice use nurses effectively? Which models offer the most autonomy if that’s what a physician wants to have and what about the
relationships with payers? How can we deal with payers in a different way? So these are just some of the questions we’re going to ask. I’m not going to get into the weeds on this because we’ve just started this process but -what we hope to do is leverage the findings that we have. We already have a physician innovator group. We have groups that are already working in new models of delivery and then we’ll get tools and resources out to physicians across the country so that physicians can choose the kind of system or practice that they want to be in likewise can be better educated about what kind of physicians can work best in their particular setting.

And finally our third strategic goal is to improve medical education. I think as many of you know it was the work of the AMA’s Council on Medical education in the early 1900’s that led to the Flexner report and the implementation of standards for physician training in the U.S. But it’s been over a century since medical training was evaluated and updated in any comprehensive way. In 2005 the AMA launched the initiative to transform medical education to examine the gap in current physician training and the future needs of our healthcare system. And what we found was a clear need for reform in medical education, more flexibility and individualized learning, training and teamwork and professionalism. So medical students and residents were already trained to go into those systems that I talked about and to have measures to promote continuous improvement and increase patient safety.
Over the next five years the AMA will convene a national team of healthcare leaders to help us develop innovative models and new education models. We are going to work with selected medical schools across the country to begin implementing these ideas and an RFB’s going to be going on--out shortly if it hasn’t gone out already.

Now while we are just beginning this process, again this is a very early stage of this, let me just tell you about some of the goals of this process. We are hoping to help students better understand how healthcare is financed and delivered. We want to promote flexible and competence driven medical education rather than calendar driven training. We want to promote skill development that emphasizes performance improvement, patient safety, and team based care. We want to enhance the development of professionalism throughout our medical environment. And in short we’re going to be doing everything within our capabilities to make sure the 21st century medical education meets 21st century healthcare system needs. So if we can actually do these things and again, these are big, audacious goals, we think that we can influence healthcare--the healthcare in this country in very significant ways. We think it can actually shape a brighter future, both for physicians and for the country as a whole. So just imagine the possibilities if all of this works out wonderfully.

We’re going to have improved health outcomes and have those achieved at a lower cost. We’re going to have healthier patients who are more engaged in
their own well being. We’re going to have physicians working in a more coordinated, efficient environment that they themselves have helped create. We call the leader of this strategic team our physician satisfaction doctor and we’re going to have a new generation of doctors trained to transition seamlessly into this world of 21st century medicine. So again, big, big goals. You’re going to be hearing more about these as the strategic plan gets implemented. I hope we can reach maybe 80 percent, 90 percent. If we can reach 100 percent, that’s good. But it took us a long time to get to the moon and it’s going to take us awhile to get to these big goals also.

So given everything I have described it’s clear that we do have significant ethical challenges facing us as physicians. These are perhaps greater than we ever had before when we focused mainly on the individual patient that was in our exam room when we’re looking at the needs of our whole society. And so every time a patient walks into a room there are a number of obligations that we have to be thinking about now. We have to have an obligation to that individual patient that’s in front of us. We have an obligation to the collective patient, to the larger healthcare system and we have an obligation to do as much as we can to fight the challenges of the day from cost to chronic conditions to sub-optimal health outcomes. And none of us need to face these obligations alone and when there’s a troubling issue that comes up we can consult our colleagues and refer to ethical guidelines.
I’m sure you have an ethical committee and group here but I do want to refer you to three AMA resources if you’re not familiar with them. Certainly the AMA medical code of medical ethics which comprises our principles in medical ethics and the opinions of our counsel on ethical and judicial affairs, our virtual mentor which is a monthly online ethics journal with articles, case studies, analysis of relevant health law. It focuses on a single theme like confidentiality or shared decision making. The virtual mentor is especially good for medical students and residents. It really provides a case vignette, a real time case which has ethical experts talk about it. And then we have the ethical force program which explores ethics for healthcare organizations rather than for individual physicians.

So finally in the midst of the details of the last 45 minutes or so I hope I’ve gotten a few core messages across. One, this is a time of really historic change. And it’s been, for me as AMA president, it’s really been a privilege to be riding this crest. It’s a difficult time in many ways. We’ll have a better idea, again, about what’s going to happen next week after the election but clearly whatever happens in the election, things are changing very dramatically and how healthcare is delivered in this country.

Second, while there are significant challenges that I talked about, significant challenges on the ethics side, on the resource side and how we think about how we’re going to treat patients and work in the healthcare system there also are terrific opportunities available to us that we didn’t have before. I
just touched the surface about accountable care organizations. The fact that CMS has put up 170 million dollars to get these accountable care organizations going or the fact that we have the Center for Medicare and Medicaid Innovation which has ten billion dollars available in grants for pilot programs across the country. Three thousand programs have already applied for those. We’ve never had that kind of funding for innovation in healthcare before. Maybe some on the private side but have never gotten that kind of financing. We’ve got the comparative research effectiveness arm of the Affordable Care Act which actually will help us to compare the kind of treatments that we render and make sure that we render the kind of treatments that are cost effective. And three, right now today we really do have an unprecedented opportunity to shape healthcare in this country as physicians.

So right now we are at a crossroads. I think we are defining who’s getting healthcare, how they get it and how we pay for it. So if you haven’t done so already I hope you’ll consider to--if you’re not a member of the AMA that you will join us. We need your help. We need your voice. We need your input because I think together we can create that ethical healthcare system that I talked about, a system that’s effective, a system that’s efficient, and a system that is ethical. So thank you and I look forward to your questions.