

**Unfiltered Voices of NY's Top Doctors on Health Legislation**  
**A Betsy McCaughey Forum on Medical Excellence**  
**October 19, 2009**

Betsy McCaughey: I want to thank you all for being here tonight. I'm looking forward to a really lively conversation. For the past nine months or so of the health reform debate, doctors have frequently been vilified and seldom been consulted. So tonight is a night when doctors are going to do all the talking. On October 5<sup>th</sup> the President invited a very large group of physicians to the White House for a Rose Garden ceremony and handed everyone attending a white coat, but their role was limited to applauding rather than actually talking.

Tonight will be different because we want to hear the concerns of highly regarded physicians who treat patients every day. What would you like to change about the current medical system? What would you like to preserve and protect? What about the current legislative proposals do you think is very good? What, if anything, do you regard is unwise or dangerous?

After the evening's deliberations are completed, we will make a transcript of everything that was said tonight and make it available online. More importantly, next Monday, a week from today, we will be delivering that transcript to members of Congress, all members of Congress as well as other policymakers in Washington DC together with a summary if that's possible and video highlights. Even more importantly, we're going to be putting highlights of tonight's discussion up on YouTube so that the nation can get a second opinion and a third opinion and a fourth opinion, and in fact sixteen expert opinions about the legislation currently being pushed through Congress.

The topics you'll see on your agenda were suggested by you, but we don't have to stick to them. This can be as free-ranging a discussion as you want it to be. Tonight, the physicians are in charge. The first topic you'll see on the agenda is the impact of guidelines on the doctor-patient relationship. When the Stimulus legislation was signed into law last February 17<sup>th</sup> it provided in part that protocols would be delivered to doctors electronically via computer on what the

government deems appropriate and cost-effective care, and beginning in 2014 doctors who are not meaningful users of this new system will face penalties from Medicare and Medicaid.

In March, Dr. David Blumenthal was appointed National Coordinator of Health Information Technology and on April 9<sup>th</sup> in the New England Journal of Medicine he expanded a bit on what these protocols would mean. He explained in that article that “embedded clinical-decision support”, his phrase for computer guiding doctors, would be employed to persuade physicians to practice in a way that the government deems appropriate and cost-effective and the doctors who feel a loss of autonomy, he predicted some might rebel and petition Congress to change the law or simply reconcile themselves to penalties rather than adhering to the guidelines.

So, all of the current legislative proposals, address the issue of guidelines in some very broad language. I’ve asked Dr. Jeffrey Borer to open up the discussion on the issue of guidelines and their impact on the doctor-patient relationship and we’ll take it from there. As each of you chooses to join the conversation for the first time, please identify yourself and it’s up to you what you want to tell us about yourself. The opinions and insights expressed tonight are your own, not necessarily those of your institution. So, Dr. Borer - and please use the microphones even though it’s a small room because then we can easily make this usable on YouTube.

Dr. Jeffrey Borer: Thank you, Betsy. You’ve asked me to make some comments about the impact of guidelines on the doctor-patient relationship. I think before I can do that in a meaningful way, I need to talk about what guidelines are because these can be misunderstood. Guidelines are consensus documents. They’re created by a committee and they’re meant to provide opinions about how to evaluate and manage the average patient. They’re very valuable, especially if a doctor is faced with a patient who has a problem that isn’t totally familiar to him or her because guidelines provide a very reasonable starting point and sometimes much more than starting point for evaluating and managing

a patient, but there are some limitations and we have to be aware of what the limitations are.

First of all, there really isn't an average patient. Every person that you see with a medical problem has some unusual or unique characteristic and this often has to be considered in dealing with the problem. A second limitation is that these guidelines are constructed by committees of eight, ten, fifteen people who are experienced but who seldom fully agree on anything. So in the construction of guidelines there is a fair amount of horse trading that goes on until a result is reached that no one may be totally happy with but everybody can sort of live with. Guidelines are needed and these discussions and consensus documents are created because definitive data on which to unerringly base management strategy seldom exist. If they did, then guidelines committees wouldn't be necessary. I'll give you an example.

An area in which I'm very active is the evaluation and management of patients with heart valve diseases. In 1996 a set of guidelines was published from the American Heart Association/American College of Cardiology that suggested that patients with a leaking heart valve, specifically a leaking aortic valve, should be treated with vasodilating drugs - drugs that lower blood pressure - and that the predominant drug should be an angiotensin converting enzyme inhibitor, a special kind of drug that's used commonly in patients with heart failure and with high blood pressure. That was 1996 and the recommendation was made at the level 1A, which means: "Yes, we believe this is right and we have some evidence."

When the second set of guidelines came out in 2006, this recommendation had been denoted to 2B which means: "Well, you could do it but we're not really sure and in fact we really don't have any evidence." What had happened between 1996 and 2006, what had happened was that two studies came out. One suggested that vasodilators and specifically angiotensin converting enzyme inhibitors were bad for patients with leaking aortic valves and the other suggested the same thing. Neither of these studies was definitive.

That's the problem, you see. The kinds of definitive evidence that we'd like to have seldom exist. Those kinds of studies are expensive, they're difficult to do, they take many years, but what we had was very little evidence in 1996, two studies that were much more to the point by 2006, totally changing the guidelines. That's not an uncommon scenario.

The point is that guidelines are very useful. They represent a reasonable approach to the average patients and to many patients a good starting point, but they are not definitive. So in answer to the question that's been raised: "What's the impact of guidelines on the doctor-patient relationship?" guidelines step in between the doctor and the patient. If it's necessary to respond to guidelines rather than what you see, feel and hear when you're evaluating a person, then perhaps you're going to do something that isn't really the right thing to do because the guidelines aren't perfect. If they were, if the data to support them existed, we wouldn't need them.

So I think that guidelines are very valuable, very useful, very important, but they have important limitations and ultimately in the worst case scenario they stand between the doctor and the patient.

Betsy McCaughey: Dr. Richard Amerling also wanted to launch this conversation. Glad to have you.

Dr. Richard Amerling: Thanks very much. I've been a critic of guidelines going back to 2003 when they first really started to make an impression on the nephrology arena which is my field and the dialysis arena, and I wrote a couple of critiques of them that drew me quite a lot of heat particularly from the National Kidney Foundation who now won't invite me to any of their meetings anymore.

I have a more cynical view of guidelines I'm afraid than my distinguished colleague. I actually believe that they do more harm than good and the example that you site is a good one because during this interval of time when the treatment was being recommended for

ACE inhibitors for leaking aortic valves, how many patients were harmed by this?

This is the problem when you have a central committee handing down some sort of knowledge from high on. If they get it wrong, they have a potential to harm many thousands of individuals. If you make a mistake in your practice you're perhaps harming one person and you can correct that mistake in many cases, in many instances. But if you come out with a guideline and it's really off and there are many examples of - You harm thousands of patients and it's very hard to pull back a guideline once it's out there. They achieve a life of their own. So I want to give you a quick critique of guidelines from my perspective.

The panel of experts are chosen - Well, exactly how are they chosen? These guidelines come about usually in the context of the specialty society and most of the experts are recognized experts in their field and they are also academicians. Now I have a certain academic bent as well but I do more practice than academics. So there is this schism between the academic elite part of medicine and the actual practitioners of medicine who are on a daily basis doing the care and this pervades medical practice. So we have the elites telling us now how to practice through guidelines and they often don't have the clinical experience that many people working out in the trenches do.

They also interestingly have very significant financial conflicts of interest with the pharmaceutical and other industry sponsors of guidelines. In fact, guidelines are a recent phenomenon in medicine. They weren't even around 20 years ago. They are strictly speaking a product of the industry. They are almost invariably financed either directly or indirectly by industry and somehow this financing allows them to have some say, and I don't have any memos, any smoking gun type of memos to provide this, but I am very certain of this because there is an extremely large percentage of guideline writers who have very strong industry ties and they document this. However, that does not erase any potential bias, unfortunately.

So industry generates these and they are largely, when you start to look at these in that way you see that it's actually in a way subtle advertising through the guideline process and I'll give you some examples of that. The process by which they are made is time-consuming and extremely cumbersome such that by the time they are actually released they are often years out-of-date and have been surpassed by better evidence. The evidence that is used is suspect in many instances. Now the gold standard in our field is the double-blind randomized controlled trial of which there really aren't that many. So as you say correctly, we're left with what comes down to opinions and use of questionable types of evidence.

Even these randomized controlled trials have their own limitations. There's the old concept of absolute versus relative risk and you could have a very strongly positive study in terms of relative risk reduction which when you look at the absolute risk reduction you're talking about one or two percent which may not be clinically relevant, and there are also many examples of this. So, here's a good example. The diabetes guideline, treatment of type 2 diabetes has long been based mainly on data from type 1 diabetes which is really a very different disease state. Type 2 diabetes that we see for the most part, are obese folks who have the metabolic syndrome.

Well, the treatment standard of lowering hemoglobin A1c or the glycosylated hemoglobin as a marker for glucose control results in most patients' weight gain when you give this very aggressively, which is their underlying disease. So you actually have a guideline that is telling you to make patients gain more weight through the use of medications such as insulin to treat type 2 diabetes and this worsens their underlying disease. Now this was never a good idea, even going back to the UK PDS study. There was never any evidence that this type control was effective but the recent data that all came out in three big studies in the New England Journal of Medicine last year, all confirmed this notion that there is no benefit to hypoglycemia control. In fact in one of the studies, the core study that the patients who were tightly controlled dieted at a higher rate.

Now the philosophical critique is also very obvious. As my colleague said, the guideline committee inserts itself between the patient and the doctor and this is the model for control of the medical profession. So if the guidelines will then become mandates, the mandates will be enforced by pay-for-performance. If that doesn't work, they'll come up with more stringent ways to get you to comply with these guidelines, and virtually any kind of outcome that they want to achieve such as, for example limiting intensive care use in certain patient populations, these would now become codified in guidelines and then reinforced by payment mechanisms at first or stronger incentives if that doesn't work.

So the central committees that are doing these guidelines cannot possibly have the local knowledge of the patient that the doctor has who's taking care of the patient. So it's an exceedingly bizarre concept that we're somehow going to be practicing better medicine by having a committee to make these decisions that we are really best equipped to make ourselves.

Lastly, look at who benefits from guidelines. It's the industry that are financing them, the payors' benefit because it gives them the methodology to control reimbursement and therefore to limit reimbursement and to control us and get the outcomes that they are looking for which are not necessarily our outcomes or our patients' best outcomes. The authors of these guidelines get benefit because they get invited to give lectures to explain the guidelines because no one can really understand them, and they get invited around the world to write more guidelines and there's also other ways to fund these folks, and the specialty societies that finance the guidelines get a lot of money for doing this. So it's a tremendous cash cow for them. So everybody seems to benefit from these except I believe individual physicians and patients.

So that's my critique and I think guidelines ought to be abandoned. I think they actually do more harm than good and they give the payors ammunition that they use against us. Even though in every guideline there is a disclaimer saying that you must incorporate individualized

data and you should not substitute guidelines for the advice of a physician, there is no way, once they publish the guidelines, for them to retain control of it. So the guidelines then could be taken up by the payors and applied to us regardless of this disclaimer.

Betsy McCaughey: Dr. Siegel?

Dr. Marc Siegel: Just to add to this in a slightly different way, the guidelines now are going to be increasingly contributed to by these comparative effectiveness trials and I just want to comment on that briefly because first of all the subjects in those trials are often cherry-picked and that patients that we're actually struggling to take care of in real life are the ones that would be excluded from the trials. So that limits the amount we can draw from these results.

Secondly, they're overly dependent on death rates as a final analysis when in reality practicing physicians are dealing with trying to keep people alive, like also the quality of life that they have. So it's hard to practice the art of medicine when you're over-relying on studies that are very limited, use very small subject - exclude people for reasons that you might not have in clinical practice you would not exclude them; you'd be treating them.

The last one I want to bring up with this was there's a spectacular example of this in what happened in the University of Pennsylvania regarding the issue of radiation seed implants. Probably everyone in this room is familiar with this. The comparative effectiveness studies were based on research at the VA of the University of Pennsylvania which everyone felt must be state-of-the-art, top-level treatment and they looked at clinical trials over several years using radiation seeds and came to the conclusion, and several assays were published on this and with the comparative effectiveness data for this area that concluded radiation seeds were not as effective as radical prostatectomy.

Only one problem: it was operator-dependent, as many of these studies are, and the needed guidelines are drawn from studies that are

operator-dependent. It turned out the person that did most of the trials was not adept at it and actually currently I believe it's under investigation for 114 patients that either suffered burns from this or advanced prostate cancer, illustrating that the data that would have led to the guidelines was erroneous because of poorly done studies.

Betsy McCaughey: Dr. David Fields?

Dr. David Fields: David Fields, I'm an obstetrician, a gynecologist and in my spare time an attorney. I think there are two other problems with guidelines which is first of all even when they are correct what they do is they tend to forbid better than average medical care; guidelines or always average medical care. They may help the physician who is not capable of achieving average results but they tend to cramp the physician who can do better than average.

The second is that even when we have randomized controlled studies in my field, in gynecology, we have the Women's Health Initiative. Women's Health Initiative is a \$600 million study. It is the worst piece of garbage ever foisted on the American public, and is illustrative of two statistics quotes. The first I believe is from Benjamin Disraeli: "There are three kinds of lies - lies, damn lies and statistics." The second is mine, which is: "The data never lie but they don't tell you what the question is. They just tell you whether the answer is yes or no or maybe."

Unfortunately in the WHI study which was supposed to ask the question: "I'm 50 years old, I'm going through menopause, should I take hormones or should I not take hormones, and if I should, what should I take for how long?" The question it really asked was: "I'm 65 years old, I've been in menopause for 15 years, I took hormones for about a year a long time ago - Should I start taking Premarin now?" Interestingly enough, the answer they came up with was a resounding "No" but when you actually look at the statistics, the answer was really "Maybe not." Then the second half of the study came out which was Premarin alone, but because of the way the study was released, it made it into the press in the form of a press conference four months

before the paper was ever available for review by a physician, at which point it was old news.

I sat with that study for a year and a half going through the data which were abstruse and it became obvious that it was young women were totally excluded from the study and what they were looking at was what we call secondary prevention, not primary prevention and which meant it was inapplicable to most of the people who are going to be on hormones.

Betsy McCaughey: In fact, several women in this room have probably grappled with the misconceptions that came out of that study. So far we've certainly identified some of the problems with guidelines in general, but perhaps some of our commentators can layer in the problem of guidelines that are enforced with penalties, financial penalties against physicians who don't adhere to them. Yes, Dr. Borer.

Dr. Jeffrey Borer: I think Dr. Amerling said it if there are such penalties, and Dr. Fields did as well. If there are such penalties it's going to be very difficult, number one, for doctors to avoid acting according to the guidelines no matter what caveats are put in the guidelines, and the tendency is down towards the average rather than beyond. I would like to add to that a little bit. There have been several comments with which I agree but they are illustrative of overarching issues that really are not so well recognized, certainly not by the public and not even perhaps by the entire physician community.

No study, no single study can answer every question that we would like to have answered. Whatever questions are answered by a study relate to the population that was studied which, as you said, may not be the large population from which we draw up our patients. That's very important. There really is no way to extrapolate wildly from any single study but single large randomized controlled clinical trials are expensive and they take a long time to complete. So it's very difficult to conceive of how we'll ever have all the information that we need to be able to definitively determine how we should treat each patient on

the basis of good data. That means the judgment always is going to be interposed.

The second point was about mortality versus quality of life and I think this probably is something that will come up again and again here tonight because of the concerns that have been raised about care or denial of care to people as they get older. Again in my field, in cardiology, often we see people with cardiac problems that develop. In fact cardiac problems are diseases of aging. One of the more common problems that people have as they get older that's cardiac is a disease called aortic stenosis. That's a problem that involves the inability of the valve leading out of the big heart chamber to open properly that puts a lot of strain on the chamber and can create chest discomfort, heart failure or even sudden death.

Well, when somebody is 85, we can relieve that aortic stenosis with an operation with really very acceptable safety, low mortality rates, etcetera. We can do that. We can't do that with medication. There is no medication to use to relieve this problem. We can do it with surgery. Surgery is costly. In an 85-year-old, are we doing this to prolong life? I would say not. I would say, however, that if the 85-year-old cannot walk down the street because he or she is too breathless to do so or has chest pain or feels light-headed or could faint and break a hip walking down the street, then there is really a very good justification for offering the therapy that is available to improve quality of life for however long the patient may live, which these days could be several years, many years. So I think the issue of mortality as the endpoint versus quality of life is a very important one.

The final point that was made was about the press. How is this presented in the press? How are these things presented in the press? It's unfortunate that many of the issues that we grapple with are presented in the lay press and the news media in a way so as to garner attention. I would not interpret the data the way the newspapers do in many cases, and I think that's a problem that we all have to deal with. We don't do a good job of telling people what we think should be done or shouldn't be done when someone is sick. The newspapers do it

much better than we do but they tell a different story than we would. Now that's a problem that we have to deal with.

Betsy McCaughey: I hope since you're going to go next again, someone will weigh in also on another complexity in this issue which is, we've already considered many of the problems with imposing guidelines on a physician's decisions for a particular patient, but what about when the factors behind the guidelines are not simply what's clinically best for the patient but also what is cost-effective.

Dr. Mark Fields: Well, that's just exactly what's going to happen, and the example that you give of valve surgery in an 85-year-old is just not going to happen under Ezekiel Emanuel. He's going to just say that that's a non-starter. That person has outlived their useful years, no matter how long they could live beyond that. I think that the guidelines are a fundamental assault on physician autonomy and there will be in the future guideline doctors and they will be real doctors. Or there will be nurses who will follow guidelines. I think the guidelines in a way are written for nurses or other allied health personnel because we're giving them sort of an outline or framework but they don't have the depth of training to be able to figure out when to apply them and when not to, when it's good, when it's bad. Only physicians really have that training that involves physiology and biochemistry and all that stuff.

Betsy McCaughey: Yes, there is an irony that now when the pace of medical knowledge is increasing so rapidly, at the same time there's this trend to dam down the provision of medical care. Dr. Rosenblatt?

Dr. William Rosenblatt: The interesting thing, along with what you were saying, Dr. Borer, I'm Bill Rosenblatt, I'm a plastic surgeon. One of our big [unintelligible] was deep venous thrombosis, pulmonary embolism, cause of death in a perfectly healthy individual. So we invited the new Chief of Medicine at our hospital to talk to our department about this and to give us some guidelines. At the end of an hour's conference he basically looked at us and said, "There are none. You have to use your own judgment." That's what comes down in medicine. So much of it is still our own judgment and it's very difficult because there are so many different

people that have so many different problems to write one set of guidelines that covers something for everybody.

Dr. Marc Siegel: Guidelines really are harmful also because they create the illusion of knowledge. They claim to know something that we don't know and they claim to be able to assign a treatment protocol when it really comes down to individual judgment. So it does us all a disservice.

Betsy McCaughey: Unfortunately, unlike the Supreme Court you never get to see the minority opinion.

Dr. John McNelis: Hi, I'm John McNelis. I'm a surgeon [unintelligible]. I just want to get back to the issue of the 85-year-old with the valve. I think the way the legislation is going is that they're not going to pay for it which is what goes on in England, which actually puts physicians and the hospitals in a very precarious situation because the other part of this health [unintelligible] is that healthcare is right. So being close to Mineola there, there are all kinds of law offices on Old Country Road and they're down there with Queens Boulevard and I can just see what's going to happen next. There's going to be a court case decision denying this woman you'd like to help and you're not getting paid - another problem. Then what's to be done? So at some point that little conflict needs to be, if we're going to go through with this, that conflict has to be resolved. In good conscience, you can't really walk away from anyone, even an 85-year-old who's up and walking around who you're going to return to some kind of quality of life just because the government won't pay you.

Betsy McCaughey: Yes, Dr. Cohen?

Dr. Seymour Cohen: I'm Seymour Cohen. I'm an associate clinical professor of medicine on Oncologic Science at Mt. Sinai, New York. The interesting thing about guidelines in today's Wall Street Journal is an updated editorial by a physician who says there were guidelines to give women hormonal replacement therapy and he tried to argue with his mother's obstetrician about giving her hormonal replacement therapy. Unfortunately he did not and his mother developed breast cancer

several years later which is a known complication. So the point being made that sometimes a doctor who's been mainly with a particular patient knows the history, knows everything, will make a better decision for that patient than a national guideline.

Betsy McCaughey: Yes, Dr. Eck?

Dr. John Eck: Yes, John Eck. I'm a family practitioner at Central Jersey. Guidelines can sometimes make physicians in a precarious position where you're responsible for something that you cannot control. By that, I mean patients themselves who are noncompliant with the guidelines, and so therefore you have to operate outside the guidelines as a consequence, and therefore you are given a double. So you're responsible for something you can't control and the outcome in fact is dependent on the patient, not necessarily your judgment.

In one case that I was involved in a liability case which fortunately I won was a patient who had rectal bleeding, abdominal pain. The guideline was obviously, get a colonoscopy. I documented that; the patient refused. The patient said, "I can't take off from work. I'm a per diem worker." "Okay," I said, "Well, I will do then what you should do in my mind. If you will not go for a colonoscopy, you will not take off from work, I will at least do a sigmoidoscopy in my office to see if I can find anything, but keep in mind and I don't document it, if I don't find something visible, that does not mean you have nothing. You should continue to look," and I documented it.

The attorney said, "No, you should have done nothing. I will sue because the guideline was colonoscopy. You did not follow the guideline." So you're given a damned-if-you-do, damned-if-you-don't and I can see down the road where the guideline police will make us toe the line and we will be responsible for what we cannot control.

Betsy McCaughey: There are already some penalties proposed in the current drafts. In the Baucus plan which isn't in legal language yet but in the plan, the revised plan on page 102, it makes a very large change in Medicare. When Medicare was established in 1965 the federal law barred the

federal government from interfering in a doctor's treatment decisions for patients. Over the years, as you all know, that's been whittled away somewhat but this new proposal really finishes it off, finishes the job by requiring that doctors will be reimbursed under Medicare not according to a fee-for-service scheme as now but according to a quality-per-cost ratio that will be devised by the Secretary of Health and Human Services and of course guidelines will be at the crux of that. What did the doctor do, what is according to the guideline, is it a cost-effective guideline? So I wondered - I know that there are some physicians here who do take Medicare on and I wondered what your views would be on this.

Dr. Jeffrey Moses: I'm Jeff Moses, a cardiologist from Columbia. I've been involved in many clinical trials and certainly when we talk about comparative effectiveness and more importantly cost effectiveness, these analyses are very tricky with many imputed assumptions. For instance when we first were developing a drug-eluting stent we embedded a cost effective analysis at the outset, in the trial, very detailed on about half the patients that were in the study and it was actually part of the scheme for developing the reimbursement from Medicare and it was pretty dominant a strategy in most patients. As a matter of fact when you look to subsequent Medicare data, costs were reduced, mortality reduced, heart attacks were reduced.

It was very effective, but you can tweak this data in many different ways in paper studies. For instance in England, they came to a conclusion with the NICE that these stents were only effective specifically only in off-label indications. If you look at NICE, they will approve 80% of the drugs. You look at Canada, you look at New Zealand, they'll reimburse 40% of the drugs, whereas the evidence is interpreted predominantly with the background of an economic sub-strait and that's the danger.

More importantly when you look at these qualities and all these data sets they impute differences in mortality in studies that don't have difference in mortality. They take numerical differences which are statistically invalid and extrapolate them over several years. So these

are very tricky analyses and invariably when you're dealing with agencies that have unlimited dollars to spend, they're going to pick the studies they like and that's the problem.

From the overall aspects of guidelines, I don't have any intrinsic problem with guidelines in the sense that they're good literature review. They're certainly better than sound bite medicine which is unfortunately what's practiced now. You could go on for days about a very important trial, [unintelligible] trial and that has devolved into a sound bite, really hurting many people and if you really look at them it really shows you there's a breathe, degrees of truth, that's why they categorize them, and there's also its consensus document, i.e. there is an array of interpretation of the degrees of truth. That's not intrinsically bad.

The problem is these things are taken as cost measures and quality measures. A good example of that for instance is left main disease which is the main artery blockage in the heart. Traditionally that has been a surgical province. Now there are studies that are coming out and fairly robust studies and growing studies that indicate in certain circumstances maybe stenting may be just as good. Not that it is as good, we haven't definitively proven, but right now it's a Class Three indication, i.e. you do it, you've hurt the patient.

So people, even in older patients who really aren't good surgical candidates, they're getting surgery because in that hospital the quality committee is going to indicate that you will get a ding if you stent that patient. The data are moving so fast, it takes years to develop one of these documents. Besides the committee they have to go through multiple societies and approvals by the Board of Trustees. These things are at least several years out-of-date by the time they are published. So I think if they are acknowledged for what they are, that's fine. The problem is they're going to be used as political and economic documents. That's the problem.

Just one last thing - I like the idea of using it for nurses and this will turn into our idea of specialty care and general care [crosstalk] but I

think guidelines are great and a lot of the basics of well baby care and adult medicine should guideline-based and it should be done with a single practitioner overseeing large groups of physician extenders who can apply this on a triage basis. Then when they fail or they're not working or they have individual side effects or the like, that's when the physician should be intervened when you're dealing with these sort of more generic public health problems. So I think in that case it can be very powerful.

Betsy McCaughey: I'm really glad you raised that because it's just about time I think to move along. Americans are being told very frequently this year that they overuse specialists and push up healthcare costs in the process. So I'd like to hear from all of you about what you think of this push that's present in every single bill, all five versions in Congress right now, a push to redirect resources from the training and reimbursement of specialists to the training and reimbursement of primary care doctors. They say it will be budget-neutral, meaning fewer specialists trained, lower reimbursement for a specialist, more primary care doctors trained, higher reimbursement for primary care doctors. What are your views?

Dr. Jeffrey Moses: This is my charge to start with. As a cardiologist, as a clinical trialist, as a practitioner, I'm outcome-based and on of the things that just defies my imagination, these discussions, what have been the outcomes or the scenario in cardiovascular disease? It's been astonishing what we've done. We've reduced and with the growth of the specialty - I'd say it's one-to-one - we've managed to reduce cardiovascular mortality by over 50%. Now what's interesting is I remember in the mid '90s when it's dropped dramatically. People said, "Well, we're done. It's going to flatten out. We're not going to be able to do it." Well, you look at the last decade. In spite of the growth of all these "expensive procedures" cardiovascular mortality per 1,000 or per 100,000 PGs who drop.

Importantly for instance acute myocardial infarction, the mortality rate even in the last decade has dropped 40%, and that has been for instance with the advent and particularly probably directly responsible

for that is the advent of acute MI angioplasty which is “an expensive new technology.” Yet I can say compared to what we’d done, when we were training with cardiologists and there was acute myocardial infarction, we just sort of gave people morphine and watched them die. Now we’re intervening, we’re setting up care systems, regional care systems, national care systems around the world and it’s particularly gratifying to see that that’s has been very progressive and ironically, this “expensive new technology” when you look at the last decade the inflation adjusted cost between MI myocardial infarction in the United States has actually dropped and is below the inflation rate.

Chronic coronary disease you can criticize too much angioplasty and we could debate that all day. People ask me, “Is there too much angioplasty or too little?” and the answer is “Yes.” Sick people are getting it and the non-sick are and that’s a whole other discussion. Still, if you step back from 10,000 feet a lot of this has driven by the explosive growth of angioplasty in this country over the last eight or nine years, but yet the cost of treating chronic coronary diseases, established diseases, we’re not talking about looking for disease and imaging, has actually been pretty much on a level with inflation.

If you look at certain studies which have not actually - they haven’t been spun this way because the clinical trialists have other agendas, the cost of someone who gets an angioplasty out of the hospital is actually less than someone who’s on medical therapy over the last few years even if they have mild symptoms. So the problem is no one’s discussed the fact, no one, and just the fact these discussions actually do a very good job if we’re good at guidelines adherence, we’re better than the generalists. If you have heart failure or heart attack or coronaries in general in the hospital, you need to be treated by a cardiologist. Study after study shows that.

So, this is nothing against general practitioners but when you are sick, when you have an illness and you want to have the accurate diagnosis and the most up-to-date and accurate treatment, you want a specialist. I think we know from the manpower studies at CACC they

are in need of cardiologists to take care of cardiovascular disease in the country, to take care of me for instance.

Betsy McCaughey: So let me just ask you to clarify that. There's going to be a shortage of cardiologists in the coming decades, right?

Dr. Jeffrey Moses: Yes, large-scale. So this diverting resources specifically to flatten out the care I just don't see the logic in that and I don't see the data because we want to prevent cardiovascular disease. How do you prevent cardiovascular disease? Well, a good way for instance is to reduce obesity. Now, no offense, you can have an army of general practitioners. How do you get people to start losing weight? It's behavioral change. We have to take an initiative like we do with smoking. This is governmental, behavioral, taxation issues, other types of reinforcement. It's not the problems of the doctor to prevent chronic disease.

We can prevent as physicians the consequences of the diseases, but prevention is a societal initiative. It's not one-on-one for a doctor because if it could, I mean the best line I like in one of Obama's press conferences he was talking about amputations for a diabetic. He said, "Well, we realize this could have been prevented with dietary counseling." I said, "God, I wish I thought of that. If we just told that person not to eat sweets or fat, she wouldn't have lost her leg."

The problem is and what really frustrates me is they say, "We're going to prevent disease. We're going to work on prevention." Okay. After pediatric age group and beyond and besides the gynecologic stuff, just tell me exactly what you're talking about. I can probably outline maybe four or five things but you don't need an army of general practitioners to do this. You need a society initiative, well-organized healthcare with a lot of physician extenders, and of course hopefully including a lot of people in the care system. But to ding the specialists for what we've done which I think on a case-based aspect we're amongst the best of the world, it's really frustrating.

Betsy McCaughey: Dr. David Cutler who is now an adviser to the President wrote a terrific article on health affairs two years ago documenting the dramatic increase in life expectancy at the age of 65 in the United States, more than five years added since 1950, and almost all of it attributable to the remarkable achievements in the treatment of circulatory and cardiovascular diseases as you've just pointed out. Not so many achievements in the area of reducing mortality from cancer until the mid-1990s and that's my not so smooth transition. Dr. Cohen, tell us what you think...

Dr. Seymour Cohen: You're transitioning to an oncologist.

Betsy McCaughey: Yes and especially if you read the letters in the New York Times today about how women with breast cancer should be treated.

Dr. Seymour Cohen: I didn't read those letters. I was reading the Wall Street Journal because I feel better after I read that [laughter]. I didn't want to be depressed when I came here. I save that for other times. The one thing to think about is people have to know some history. I'm not going to quote [unintelligible] I know we all know that. In 1900 the life expectancy of a newborn was 47 years. In 2010 they are now writing that people born now [unintelligible] may live to be 100.

We've had massive advances in longevity. The problem is we have cost. Why do we have cost? People used to die when we went to medical school like you [unintelligible]. They used to die at 66, 67 and 68. Medicare paid for two or three years, Social Security paying for two or three years. We're the bad guys. We're responsible for keeping people alive to 85. So we're now going to try to change healthcare because people are living too long. It just doesn't make very good sense to me.

The question about oncology, there is a massive projected decrease in need for oncologists in the future. Probably I think the number was 30,000 I read the other day within the next ten years. Let's talk about specialization for a minute. Let's talk about lawyers. I have a son, a lawyer who never [unintelligible]. He does healthcare law. Would we

think my son would handle a negligence case he knows nothing about? He tells me, "One of my best friends is a famous trial lawyer. He knows nothing about other things except what he does. He's a great specialist. He's gotten off some very world famous people on white collar crime." We don't go to our general attorney when we have a packing problem but they're telling us to do this now in medicine.

We have different types of engineers, even journalists. There's a financial writer, there's a sportswriter. Sure, you can get them to learn how to do a quick piece on something but this is a society of specialization with massive advances. Now in healthcare we're telling everybody, "You just go to the guy who's your general doc. He's going to know everything and maybe we'll find a specialist for you if the panel decides maybe you're sick enough to need a specialist." It really doesn't make sense at all.

Now let me address some of the advances in cancer. Dr. Moses eloquently expressed some of the advances in cardiology, but children with acute leukemia used to be totally failed. We are now curing 90% of children with acute leukemia and most of the other pediatric illnesses. The human logic diseases, Hodgkin's disease, when I was in the service I still remember air-vaccing two young women aged 29 to Lackland Air Force Base and they died. They got a good year or a year and a half. We had the first drugs, Velban and {unintelligible}. Now almost everyone is cured.

Do we get credit for someone who dies at age 30 of Hodgkin's, his wife goes on Social Security for the rest of her life and he's not working of course. Now he's working, paying taxes. We've saved society a fortune of money - Any credit for that? We're only spending everyone's money. We have money to build roads and up on [unintelligible] I sometimes travel in Connecticut, a highway that's great. You can teach your kids to drive there. It's never used. Oh, you don't have money [unintelligible]. I mean we provide jobs. We're a leading employer in New York City, but oh, we're going to cut those jobs. We are those people going to work?

Betsy McCaughey: Let me ask you something. I remember in the early 1990s when managed care became very prevalent in this area of the country. It was the HMOs who really popularized the notion as I recall that we needed more primary care doctors and fewer specialists. We overcame in the course of the 1990s many of the problems brought to medicine by managed care, the withhold, retained to some extent utilization review but now we hear again that patients need to be treated by primary care doctors instead of specialists despite so much data, as Jeffrey Moses referred to earlier, enormous number of studies showing that if you have heart disease you are much more likely to be incorrectly diagnosed, improperly treated and die sooner if you rely on a primary care doctor. We also have some family practitioners here. Weigh in, please, and tell us the other side of this.

Dr. Marc Siegel: I'm Dr. Marc Siegel. I'm an internist. I agree with everything that was just said with one exception. Dr. Moses' point is absolutely right which is that specialists do a much better job of taking care of specific problems that they are trained to take care of, and that if internists or general practitioners start to weigh in too much and take over these things we're going to get worse outcomes. But the one thing I would call attention to and I think we're going to all end up agreeing is that I don't think you can be focused as an interventionalist and a prevention-oriented doctor at the same time.

So it's a culture, it's an orientation, so here's what I would say. The health professional shortage areas in the United States count 65 million people where there are enough doctors of any kind and in the Baucus bill he's offering 10% of increase fees if you go there. Now, who's going to do that? So my issue would be let's get the primary care doctors out to the shortage areas somehow and let's not interfere with the interventionalist specialist in areas like things where they're highly trained to take care of people with specialty problems. So that was the point I wanted to add. I think we can co-exist.

Dr Seymour Cohen: Absolutely. I think this thing about when you go into medicine certain people it's almost like the arts and music. You really fall in love with something and most people we need to look at how much money we

can make in a specialty. I fell in love with hematology oncology as a medical student and that's what I was going to do and I knew I could earn a living and I wanted to be happy in a field that's useful and that's what I wanted to do. I know so many of my colleagues are the same people who kid me, "When are you retiring?" I say, "With all these great advances on, I do a lot of breast cancer. I mean [unintelligible] been living a life with spread disease, ten or fifteen years now with all the new drugs, some of them may be cured." We take colon cancer with metastatic disease to liver, we operate, we give them chemotherapy and avastin and all sorts of drugs, and they're alive seven or eight years later and probably cured.

I mean I find that very exciting and that's what I want to do. The young kids who go into oncology do that. I don't think if you told them you can make 15% more in something else especially primary care, they're going to want to do that. It's such an important point that they think they can direct us just by giving us 10% more which you're going to pay probably 70% in taxes after they're through with this healthcare bill. It doesn't work that way and we are not as money-hungry as they make us out to be. We really do not chop legs off for \$15,000.00.

Betsy McCaughey: Thank you. Dr. Hurley?

Dr. Matthew Hurley: Yes. My name is Matthew Hurley. I'm a primary care physician for some 25 years and represent close to about 3,000 physicians within the doctors council. My experience is that primary care, or at least I felt primary care is almost a dying field. When I came out of medical school and out of residency I wanted to be a cardiologist but I said, well, let me just hold and examine the patient in the total context. I found at least it was much more challenging, it was much more three-dimensional. If I just focused in on the heart I would be great in taking care of somebody's heart and nobody could argue that specialists are needed in the acute care context, but in terms of the chronic care context with the three-dimensional and the social issues of the patient, I think you need well-trained primary care physicians.

I think Obama and the new health bill has it right there at the base. I see every day specialists saying, "Well, you need this pill for your heart but you're on this medicine because you have a urinary problem. Go see your primary care. Let him sort it out for you." That you need somebody that's able to take the ten medications on average a senior has and be able to sort it out in a thoughtful context to deal with all the organs of the patient and the entire human being, and I see that as a primary care physician. I see them as the base of medicine and not - but I can't argue.

Specialists have made great strides in acute care medicine, but the last that I heard I thought primary care physicians were taking care of about 80% or somewhere in that range of patients who have congestive heart failure and atherosclerotic heart disease, the majority of heart disease. We need to involve the primary care physicians to make sure that they're well-trained, fund them appropriately and develop it as base because they will take care of the three-dimensionality of a patient as opposed to just an organ.

Betsy McCaughey: Okay, I have three comments going right - Dr. Borer, Dr. Rosenblatt, Dr. Siegel.

Dr. Jeffrey Borer: I think that Dr. Hurley is absolutely right that primary care physicians are essential. I'm the chairman of the Department of Medicine of a hospital in a relatively underserved area and it's very hard to find people in the community any doctor to whom to refer patients when they are discharged from the acute care facility. It would be wonderful to have more primary care physicians. But when you suggest that primary care physicians should be emboldened to deal with heart failure or with atherosclerotic disease, sure, if there aren't specialists available I think that's wonderful.

Dr. Matthew Hurley: Do the real estate people get punished for a homeless person who gets readmitted?

Betsy McCaughey: Wait a second. Dr. Siegel?

Dr. Marc Siegel: I just want to comment because I don't want it to get obscured in this set of specialty medicine versus primary medicine. I actually wanted to challenge Dr. Hurley about one thing. I don't actually believe that the current health reforms before Congress are in any way going to reinstitute primary care medicine as a priority. I mean look, two percent of the graduating classes of medical school go into primary care right now. There's been a drop of 57%. It is a dying breed and physicians can't afford to become primary care doctors anymore because they've come out \$100,000.00 to \$200,000.00 in debt. Nobody's offering to assuage that in any way. There's no way.

What is actually happening with the health reforms is we're going to get plenty of insurance but no primary care doctors to take care of them and no specialists to take care of them. So it's not an 'either-or' situation; it's 'neither.' There's a shortage of physicians in the United States growing, both primary care and specialists.

Betsy McCaughey: Dr. Cohen also put his finger on something so interesting and that is with the pace of medical knowledge increasing so rapidly, when you find an area, a field of medicine that captures your inherent intellectual interest, you want to know everything possible about it, right? Dr. Rosenblatt?

Dr. William Rosenblatt: No. Actually, Dr. Siegel sort of picked up the main area and that is in order to get more internist, more primary care physicians, you're going to have to talk to those medical students. They're coming out average \$150,000.00 to \$200,000.00 in debt and they're not always looking - I mean they have to figure out how to pay for this so we have to look at them and figure out how to help them out with their debt if we're going to encourage them to go into primary care perhaps the "lower-pay specialties." I think it is important to do that but it's up to the medical student [crosstalk].

Betsy McCaughey: Let me ask you something else and oh, we have lots of comments, just a sec. The five bills that are currently before Congress all mentioned, although some much more specifically than others, what will be a qualified plan. They all require that almost everyone enroll in what

the government deems are qualified health insurance plan. Most of them make very big references to the fact that whatever plans the Health Choices Commissioner denotes as qualified and therefore, meeting the citizen's legal obligation to have health insurance, must use some sort of payment method for physicians other than fee-for-service and must establish some way of limiting the use of healthcare. Of the five bills, the Kennedy Bill is the most specific because it makes it very clear that each plan will have to have for each subscriber, a medical home which will be like a primary care doctor and there will be some sort of gatekeeper function. Medical home is like this decade's terminology for primary care gatekeeper and the CBL last December explained that that medical home would likely use such techniques as the withhold to limit patient access to specialty care and diagnostic test. So I thought maybe we should just cover this issue from the patient or subscriber's point of view, what about requiring that patients rely more heavily on primary care doctors. Yes, Dr. Fields?

Dr. David Fields:

I think it was Einstein who said that doing the same thing over and over and again and expecting different results is insanity. I don't think that's really true but at some point, it does become stupidity. What I think is really interesting about this and the comments you made before about primary care and about restrictions of payments is that the government is in the process of duplicating everything that managed care did for the last fifteen years that was reviled by everybody and which we fought very hard to overcome and which the courts finally said, "You can't have withholds. You can't deny paying - you can't pay people to deny care. You can't have gag rules." The government is in the process of doing all of that. Massachusetts is about to establish capitation as the rule of the state. Capitation was the worst thing that ever happened to medical care and certainly, in the second half of the twentieth century. I don't understand - well, I do understand actually. The government is about to do everything that they said we shouldn't do in the private sector.

Betsy McCaughey:

Yes and almost all the bills do suggest that the Health Choices Commissioner or the presidential appointee who will be designing what

is a qualified plan, the type of plan you must have will employ capitation and other limits on healthcare. Yes?

Dr. David Fields: Could I just make one more brief comment?

Betsy McCaughey: Yes?

Dr. David Fields: What they're doing basically since the problem is insurance, is trying to put out the fire by throwing gasoline on it. What insurance does is once you pay your bills, you're entitled and there's no reason not to use the system ad lib and what we need is some sort of more personal relationship between the user and the payer which is one of the things I'll talk about when they get further on.

Betsy McCaughey: Yes, Dr. Amerling?

Dr. Richard Amerling: Yes, not only it was managed care and the whole gatekeeper model, [unintelligible] unpopular. It also horrendously failed to control cost. The reason being it was very inefficient and once a sick patient is identified to create a barrier to that patient getting access to a specialist made their care more expensive because it delayed prompt, definitive treat - you know that when you get the specialist involved in a case, they cut through a lot of stuff that a generalist would have to sort of do from square one and they are more efficient. This is why you want to get the specialist involved right away when the patients come in. The other thing is that this is, again, this is very cynical because I've seen it all before. It was back in the '90s when they tried to do this stuff and they've asked the RBRVS by promising that they were going to cut the specialists' fees, the procedure list that we got through making all this money and give that money to the generalist. Of course, everybody ended up getting cut but they just employed the classroom warfare card to try to turn the primary care physicians against the specialists. We are all in this together. There's going to be less money for everybody the way this is going and there will be too few doctors of all stripes.

Betsy McCaughey: I'd like to ask a practical question before we go on. If a bill is passed somewhere before the beginning of the year and many people suggest that will happen. According to the current drafts of these bills, some eighteen months after the bill is paid, the Health Choices Commissioner appointed by the President will with the panel of medical experts, five I believe under H.R. 3200, make the important decisions about what your claim will cover, how much leeway your doctor will have and what managed care type controls will be required to be in each of these plans. So what do you think the medical community should be expressing to Washington about the specific issue before we move on?  
Dr. Hurley?

Dr. Matthew Hurley: I couldn't agree more with my colleagues Dr. Siegel in that incentives need to be had to help train primary care physicians and bring them into areas of need. I work at [home] hospital. That's certainly a safety net hospital in the center of a very poor community which we have all throughout the country. Unless there are substantive [forgiveness] loans in some context that it would make it very difficult for young, primary care physicians to come out. Dr. Borer had mentioned getting specialists - all the specialists in line when the patients are admitted. I couldn't agree with that more but 95% of medicine is outside of the hospitals, is in the chronic care contest and to have well-trained, thoughtful, know how to utilize specialists in many ways, is I think a better approach getting more primary care physicians at the base.

Betsy McCaughey: Dr. McNelis?

Dr. John McNelis: Yes. I think the answer's one of access. The medical home system actually have worked in one specific instance and that's the Veteran's Administration System where the government really controlled everything and basically, the whole point of the VA is to get the patients come out of the hospital to the outpatient setting and it worked. This would be [seized] upon - in fact, the point of basis of the Mass plan to an extent and to know for instance, this was rolled out in Massachusetts, just where the [unintelligible] of health is, a place that I'm very familiar with and what's being set up there. At the same time, the capitation system is the [darling] of professors in the various

schools of public health. Why? It's felt that it will eliminate cost and as a surgeon, I think simply, I think how is this all going to work and I see a big pot of money in DC but they're not going to be cutting checks to us. They're going to break it down into VA's 23 different regions. They'll go break into fifteen, maybe six. Who knows? Pick a number. That region's going to get money then they're going to subdivide the money and then the medical home's going to get X amount of money to look at X amount of lives. If this sounds familiar, anyone [crosstalk] do HIV, this is what this is and there will be incentives and it does work in other parts of the country. It works in Colorado, works in [unintelligible]. Well, to work meaning it's functioning. So I think the answer's going to be access. Now, how's that going to be a [problem] with access. Well, the medical home is a great concept. It's different than a gatekeeper because possibly you have 24-hour access just to one doctor. It's going to happen as with time with capitation that Mark [Swabley] is going to become the black knight, "None shall pass." I think what's going to happen is that they're going to go to become gatekeepers because they're incentivized to become gatekeepers. The issue of this incentivizing specialists is already a problem and I can tell you the [stack] meeting state [unintelligible] state trauma advisory committee is a big problem and the people in this room, I would advise you not to get into a motor vehicle accident and you stay out of a major metropolitan areas. As for \$15,000.00 for an amputation, I wish. I'll split the fee and they don't even want [crosstalk].

Dr. Jeffrey Moses: You give it to the pediatrician.

Dr. John McNelis: For taking out their tonsils.

Betsy McCaughey: Now, Dr. Samuel Guillory had wanted to weigh in with some thoughts about ways to look at this issue.

Dr. Samuel Guillory: Yes. I'm Samuel Guillory, an Associate Clinical Professor from Sinai Medical Center and on the slide, hope your first, it states, "Will it still be there when I'm 65?" Now we know that that song really had the age of 64 and some of us in that room had passed that time. What will still be there? Well, if you look at it from the patient's point of view or

even from the physician's point of view but patients come to us to deliver healthcare but they know that there's another fraternal order that we've joined. We've become physicians and we swore to them that we'd give them ethical care. We would be in confidence with that care. Our fraternity, we wouldn't swear to a specific oath that we - it was a secret oath but rather we would create records on the patient that was secret, their records. Now, some in the Senate, we've heard in the papers recently wished that their physician had kept some of their information secret. As we know that some have had issues including some presidents in the recent years of activities out of [wedlock] and we often have been called on as physicians to keep this information a secret, sometimes the [unintelligible] issues and other issues. So the code that we're keeping a secret is the patient's records and now, we're being asked by the executive branch, President Obama the leader of that branch, the legislative branch, Nancy Pelosi and Senator Reid often in the news to break the code with the patients and deliver all their records into electronic medical records. Now, I'd like to think that records are already kept safe but each of us know what we've heard and we've read that even the Pentagon, records are not safe. Often our bank records are breached, our social security records are breached and we have a government that wants to start a national health insurance program and in order for the patients to be part of that program, they have to agree that their doctors will put all of their medical records in electronic medical form. So when I put there "What will still be here when we're 65," it's not whether we'll be able to pay for healthcare cost but what does a patient have to give up in that relationship. The second part of the slide refers to - we already have a national healthcare program. We have Medicaid and Medicare. Now, we know that the national health program was initially proposed by President Truman and he took twenty years from 1945 until July of 1965 before national program was in place and that was Medicaid and Medicare which we know as under the auspices of the Center for Medicare and Medicare Services known as CMS and that includes Part A, Part B, Part C and Part D of healthcare cost. If you look at this slide, it shows that Federal budget. These are where our dollars go, with human resources which account for approximately \$0.30 of every dollar of the budget. We have the military spending which is now about 54%

and you can see how that's to be felt. When we talk about past military, we talk about what we borrowed to fight wars. We know that that red part on that graph will grow to - for the Iraqi, Afghanistan war only, will grow to be \$1.7 trillion in the next couple of years. Then we see the general government and then you see the physical resources there. Of the human resources, the Medicare part of that is approximately 20% and of that, the doctor's portion is about 13% of that part. Of the Part B which is 13%, the [pie] physician is approximately 18% of that part. So when you have an executive branch and a legislative branch proposing that you can limit healthcare and reduce the cost with the lowering of physician's income which would only be about 9% of the 13% is a very small amount. Where have the cost increased? In 1965, the Medicare/Medicaid program began. The first enrollees were in 1966, a total 19 million enrollees. Now, we're in 2009. There are a total of 47 million enrollees and in the next five to seven years, there'll be another 15 million. That number will grow to 60 million enrollees in this program. Now, we've all been told in the news, it's in the New York Times, it's in the Wall Street Journal that we have some approximately 40 million other Americans that need to be insured and our government is trying to institute a larger national insurance program. Where is the money going to come from? Are we going to increase the taxation? We know that Medicare and Medicaid's paid from the FIAC that comes out of your paychecks each month. Or are we going to decrease the health that's being given to our senior citizens? This was a cartoon that was placed in one of the journals some years ago. For those who are listening and can't see, it says, "Don't let your patients find out the hard way about the changes in Medicare." Here we have a Medicare patient on the street with their suitcase pushing their IV pole in a hospital gown. So I propose that yes, as the first slide said, "Can we afford the changes in healthcare and healthcare cost? Can we not afford to insure all?" We must have healthcare. We must have healthcare for all in this country but the notion that we can provide healthcare for all and not increase the expenditures I think is a falsehood. The legislative body has got to understand that we must increase expenditures to deliver more healthcare to more Americans.

Betsy McCaughey: That's a really good introduction to the issue and maybe I should just throw it out before we go on and say the President has said that he's funding this program in part with tax hikes but also with a \$500 billion reduction in future Medicare funding over the next decade. That's about an 8% reduction when we expect about 30% more people will be enrolled as the baby boomers reach age 65. So many people in this room treat the elderly, either heart disease or cancer or other age-related disease. What do you think of this?

Dr. Richard Amerling: In nephrology, I'm currently writing an [au fait] on the coming rationing that's going to be hitting the dialysis payment system. In 2011, they're going to institute a process known as bundling. Dialysis payment was traditionally - well, has up until now being paid for as a composite payment for treatment for older dialysis-related expenditures within the dialysis unit. They're going to roll into that - and by the way, that's been about \$140.00 since the inception of dialysis care in 1972. In other words, the real dollar value has eroded to about \$14.00 so they rolled into this payment now coverage for all the drugs given for dialysis patients including [EVO], vitamin D analogs, phosphate-binding drugs. All these drugs are expensive so they're now going to be rolling all this in with only a very small increase in this composite payment. They're going to be putting pressure on the dialysis providers and the doctors that take care of dialysis patients such as myself to ration care to these patients who are going to have to deny use of expensive drugs. They're going to be going on the el cheapo drugs such as Tums as phosphate-binder and it's going to severely pinch dialysis unit revenues. It will put at risk a lot of these small independent dialysis units. Even the big chains are worried about this coming assault and this is rationing of care to a Medicare population that is very vulnerable. These are the dialysis patients and I want to try and get this thing out because it's an example of what's actually going on now. This isn't theoretical. This is proposed it's going to take effect in 2011.

Betsy McCaughey: Dr. Siegel?

Dr. Marc Siegel: A couple of quick comments on both Medicare and Medicaid. The first place as was already alluded to, if we see cuts - if we actually see cuts of \$400 billion to \$500 billion in Medicare, that's either going to mean in part that our yearly protection that we have against this cut [test] idea that we're going to be cut 21% and the AMA spends all of its resources fighting it, otherwise they're a worthless organization to us but somehow we're going to see those cuts in which case there's going to be tremendous attrition in Medicare. I got to explain that the Medicare Payment Advisory Commission had already determined that 30% - about 28% to 30% of patients looking for a new physician in Medicare can't find one.

Betsy McCaughey: By the way, that \$400 billion to \$500 billion in reduced future funding for Medicare, that does not take into...

Dr. Marc Siegel: Because that's in addition to.

Betsy McCaughey: Yes.

Dr. Marc Siegel: Alluding to the physician cuts, I wanted to make a point which is either you're going to see massive cuts or there's never going to be anything close to this revenue [when traveling]. This is a trick because either the cuts are going to be fought off, in which case the bill is going to be another trillion dollars or the cuts won't be fought off and you'll see hospitals closing and physicians dropping out. The \$150 billion cuts to hospital of Medicare is going to be another enormous problem especially if it's tied in with issues of bundling of care and physicians not being reimbursed or hospitals not being reimbursed for care. Just to give you one example, as many people already know here, a total hip replacement currently is reimbursing on the Medicare, \$970.00 and that includes the hour before and the hour after which are basically called unemployment time. That's not a phrase that anyone's given any attention to, the word "unemployment time." That's a common expression that's used by surgeons who understand how much time they have to block out for a simple operation. Many orthopedists are saying, "I don't even want to do total hip replacements anymore." So this is the current Medicare system. I think part of the problem is that

politicians are looking at Medicare in 1960's concepts. Back in the 1960's when Medicare came in, maybe physicians were making a better living than they are now. Maybe they were being paid more so they could cut physician. Medicare has, over the years, 21% or otherwise, cut physicians gradually in terms of procedures and reimbursements year by year by year. So putting a mindset from the 1960's onto this won't work because the physicians are already cut to the bone and many are already dropping out of Medicare.

Betsy McCaughey: Dr. Siegel, let me just ask you one other thing before we go on. How would the ordinary person who's not a physician envision the impact of these hundreds of billions of dollars in reduced future funding for Medicare on what they find when they have to go into the hospital?

Dr. Marc Siegel: Betsy, that was the point you were alluding to before which is it's inevitable that any cut to a service provider is going to lead to a cut to a service. It's really fraudulent to maintain, "Oh, we're going to maintain your benefits but your doctor won't be there or your hospital won't be reimbursing for the service." Just to give one tiny example of our point...

Betsy McCaughey: Well, that's Part B but what about Part A? Will there be enough nurses on the floor?

Dr. Marc Siegel: Well, there's a tremendous nursing shortage as well and that's not being dealt with at all. Just to give you one tiny example of this, readmission is going to be cut. That is a terrible idea for a hospital because a lot of times readmissions for things like burns or failed operations or wounds that didn't close, how is a hospital going to cover that if Medicare has decided over the top with MedPAC having more power or with Health Choices Commission is involved and somehow these services are going to be cut across the board. Medicare hospitals will end up either closing or they'll have to transfer the penalty to private insurers to make up the difference. The way, by the way, already occurs at the Cleveland Clinic which is - the President using the Cleveland Clinic as an example but the only way the Cleveland Clinic stays in business is by charging more to private payers because they're

running in the red on Medicare/Medicaid. To move on to Medicaid for a minute because I don't want to take up too much time but Medicaid is even more of a problem when the Baucus Bill is talking about extending Medicaid to 10 million more people. Medicaid already has a problem because 50% or more physicians in the United States don't take Medicaid but what is not being understood by any of the politicians is that the only place that you can go if you're a Medicaid patient is to a hospital or to a clinic. The states administer Medicaid but the states are in jeopardy here of not being properly reimbursed. They already are cutting Medicaid to hospitals under the current system because the Feds are not backing them up. State by state, and I've studied this...

Betsy McCaughey: On average, they pay \$0.86 per each dollar of care delivered.

Dr. Marc Siegel: Exactly. State by state, Medicaid - states are turning on cutting hospitals. I have all the figures for New York State which I won't go into on my own hospital but state by state, states are already cutting hospitals saying, "Well, you're not delivering enough Medicaid care and the Feds are not coming through with our full payment so we're going to cut you." Imagine what it's going to be if 10 million more people are on the rules and Medicaid has expanded. The politicians in Washington do not understand at all that it's the network of physicians and care provided within hospitals that - and residents taking care of Medicaid patients, not outside physicians. You cannot get outside physicians to take care of Medicaid patients not because they're not charitable, not because they're don't care but they don't have the network of other doctors to turn to, to take care of these patients.

Betsy McCaughey: Dr. Moses?

Dr. Jeffrey Moses: Well, you touched on several lines. First of all, one of the little slides at [hand] in the whole discussion of the cause of this is, is on Medicaid expansion which is also [borne] by the states after a trillion-dollar sort of vanished from the discussion because the states were not aware. I don't know. We're getting it from [unintelligible]. I mean that's going to come out some time, private care. The other part is when you're talking about a service providers, one noticeable absence of any

discussion has been injecting any inefficiencies into the care delivery system from the standpoint of the unions, of just organizing - spoken of healthcare systems like they have in Europe. I mean the problem I have to some extent and I think there is a medical [arms] raised. You could be any - a hundred-bed hospital if you have a donor who's going to give you a linear accelerator. In many states, you could buy one and then you have to find patients to fill it up but the main thing though was the biggest barrier of efficiencies in the hospital, at to least to my hospital, is moving the union people around. It's impossible. I mean I told you the story. I injected some pretty - not drastic but positive patient-oriented care to my floor when I came up to Colombia which are pretty common-sense things but not institution of Colombia and I had this very, very tough - that five-foot tall nurse who was implementing this and she was physically threatened by one of the shop stewards. It took us nine months just to move that patient off the floor. We're not talking about criminal charge. It's [firing]. How do you inject efficiencies into a system to respond to these [cost] things and it's been dead silence and one of the ironies I think is Obama was postulating how wonderful the recovery of Pittsburgh was. Well, Pittsburgh recovered because it became a destination care for a great medical system.

Betsy McCaughey: UPMC.

Dr. Jeffrey Moses: That system will be crushed by the laws or the discretionary ability of patients to see that type of high-level care and that's sort of the irony of his statements at the summit there.

Betsy McCaughey: Dr. Guillory?

Dr. Samuel Guillory: I think that things not being talked about in Washington is that you can continue to constrain the doctor and not pay the physician but there's only one group of people who can deliver healthcare in this country and that is the physician. If the physicians decide not to participate in a health insurance program, as many have done in Medicaid, you cannot deliver healthcare in this country. You cannot call in the National Guard or any other organized group to deliver our services and we all

know that there are provisions to allow physicians have fee-for-service care and many are going in that direction because they want to deliver good care. Many are willing to reduce their fees to patients to deliver that care.

Betsy McCaughey: Many treat patients with no fee.

Dr. Samuel Guillory: For no fee. Volunteers them but they're unwilling to compromise their medical care and a healthcare system and I think that's what have to be made very clear and hopefully, the AMA and other organized organizations will begin to push the idea that we are the providers and we want to provide the healthcare and there's no one else that can provide that. I'm not proposing that all doctors walk away from the Medicare program but we should have in the back of our minds that we're unwilling to participate in any insurance program that will restrict to deny care to patients.

Betsy McCaughey: Dr. Cohen?

Dr. Seymour Cohen: We have to somehow be proactively convinced the people of this country that we are not the only mechanism of reducing cost. We are talking about a healthcare bill that's been getting about \$100 billion at least that's spent on defensive care from malpractice and 3,000 [unintelligible] who have given enough money to the Democratic Party to prevent even any discussion of this. We also - I'm an oncologist. He's cut a deal with the drug companies. I can't comment when a drug comes out and they could decide in most new cancer drugs now cost between \$4,000.00 and \$5,000.00 a month per drug. People walk out with \$14,000.00 or \$15,000.00 worth of drugs. I don't know the cost for developing. I can't comment but I can comment that it should not be increasing by 20% a year and that's what's been happening and pharma donates something. They cut the last bill with Billy Tauzin and Scully that who had seven-figure jobs in pharma were - there was an allowance for them to write legislation. We have to direct the discussion. If you want to cut care cost, you can do it but you can't just do it totally on our backs. You still need us, as Dr. Guillory and Dr.

Siegel very eloquently just put forth. You need us to have the ballgame. There's no ballgame without us.

Betsy McCaughey: Dr. Kassimir?

Dr. Joel Kassimir: Three quick points along the lines with what Dr. Guillory had mentioned. What concerns me is that Congress gets to keep its uniquely privileged healthcare plan. They do not have to participate in what the government is now suggesting. Sam also spoke of our ethical responsibility and we're now being told by physicians, advising the President that we take the Hippocratic Oath too seriously. I've never heard that until it was published. I think it was in The Times or was it the Journal? I just didn't know how to respond to that when I met the gentleman at the Aspen Institute who was quoted as saying that. Then finally, Ted Kennedy, if he had to participate in this government-sponsored program would never have been able to travel off to Duke and have very, very expensive healthcare provided in the disease which is almost uniquely - almost 100% fatal. They probably would've asked him to go back to Hyannisport, said, "You've had a great life. You've been a wonderful senator, now go home, you're going to die." I'd like to know who would've told him that.

Betsy McCaughey: I'm glad you mentioned Dr. Ezekiel Emmanuel because in one of his articles, he does argue that many physicians take the Hippocratic Oath too seriously and focus too much on the needs of their own patient without considering the impact of those expenditures on society. What do you think of that comment?

Dr. Richard Amerling: You're absolutely right. Everything that he said about doctors having to stand up and let the government know that we're not going to go along with a rationed healthcare system that we're going to be doing the rationing plus we're going to get paid less to do that. I just also, since this is a public forum, I need to point out for the record that while I agree to everything you said, your pie chart on the budget was from the War Resisters League and greatly exaggerated the military expenditures. The actual military expenditures are around 20% or less of the Federal budget and they also did not put in social security and

Medicare because they had dedicated trust funds and of course, those trust funds are empty, so all the money is coming from general revenue.

Betsy McCaughey: Thank goodness we don't have to get into that tonight.

Dr. Samuel Guillory: The social security was actually in that upper pie chart and the reason why I took this particular chart to look at is that we have many expenditures in this country that are not applied to military. When they give budget to universities, large numbers to some of our universities to do work and also to private corporations and this chart took it into account and that's why I chose that. Having come from the industry when I was an engineer many years ago, I can tell you that many things are hidden in the military budget. Rightly so, I don't argue for that because there's a lot of good that comes out of it, a lot of good medical care. The reason why we have post-op seminars and so on came because of the military budget but we should hide that. I had to go back to the part that I mentioned about the oath and what's important about it. When surveys have been taken in this country of the general population and they asked which profession and which person you should hold to the highest ethical standards, physicians are always at the top of that list. Always. By no other profession, nor the people that you survey even if you will survey people who are in the legal profession and the legislative body and the general population and that's why we take the oath serious. When we are holding things in confidence because we are ethical, by standard and the population expects us to be and that's part of being a physician and I deplore the term "healthcare provider." I do not let anyone call me in the office and refer to that term. In the conversation, I have to [send] the call back in my office and use the term "physician." My staff wouldn't ask for me. They must maintain that word throughout the entire conversation. That's why I hold the oath. I am a physician. I'm delivering good care. I do not participate in any insurance program. I will not participate in an insurance program if I have to give every patient that walks into my office free care. That's what we're about. We are physicians, we're not healthcare and the sooner my colleagues begin to scratch out the terms and write in "physician" on type of

healthcare which I will do on any form that comes to my office and [unintelligible]. We are physicians. We're providing good healthcare.

Betsy McCaughey: That's great. Dr. Pfeifer and then Dr. Siegel.

Dr. Tracy Pfeifer: I wholeheartedly second those remarks. I'm a plastic surgeon practicing New York. I have wanted to talk about the Hippocratic Oath for some time and I mention it to all my patients when they come into the office. Since we're going to be on You Tube, I just want to make it known to the public that when physicians graduate from medical school, we take an oath, the Hippocratic Oath to do no harm to our patients. It's a very important philosophy to us and we uphold it and hold it very dear to our hearts. Plato, another philosopher used to say things like, "Those with a poor physical constitution should be allowed to die. The weak and the ill-constituted shall perish." These government programs that are being proposed I think are very scary in the sense that physicians could be induced to violate the Hippocratic Oath particularly with regard to the mandates. I think that could directly force physicians to violate their sacred trust to their patients and we absolutely should not see them in court.

Betsy McCaughey: Dr. Siegel?

Dr. Marc Siegel: Dr. Guillory made an excellent point that I just wanted to repeat. Well, I don't have to repeat it but the point is physicians, people always ask me, "Why don't physicians just revolt" and that's a very hard question to answer. Well, one thing's for sure. Physicians don't have to play ball with insurances they feel are not treating them properly. In terms of the point about Hippocrates, another thing that's striking here about why we should be involved in this and dead center in any kind of health reform is the way physicians are trained and I wrote about this in USA Today. The way physicians are trained is to look at everyone the same. We take all comers. We don't differentiate. We don't do what Ezekiel Emmanuel wrote who's non-practicing wrote in a Lancet which is we don't look at life-years. We don't say this one has more life-years than - this guy's used up his life-years and the fact is we look at all patients the same. We don't

differentiate based on color, based on age, based on gender. Any which way, in fact we go by the oath of Maimonides which says, "Our patients are just fellow creatures in pain." Fellow creatures in pain.

Betsy McCaughey: Yes, Dr. Fields?

Dr. David Fields: One word on quality of life-years. I think pretty much every study that's ever been done...

Betsy McCaughey: Use the microphone please so we don't miss it.

Dr. David Fields: One word on the quality of life-years and then two words on Medicare. As far as quality of life-years go, I think pretty much every study that's ever been done with people who are old, who are sick and who are in moderate amounts of pain is that they'll take the next ten minutes of life if you offer it to them. Very, very few people want to walk out through that door. As far as Medicare goes, while we're on the subject, I'd like to say two things about it. The first is Medicare has over the years, typified pretty much everything that's wrong government-run healthcare. I know that patients are very happy with it because they expect to be covered. My own personal experience with Medicare dates back to 1984. In 1984, the then Inspector-General of the United States sent a brochure to every doctor in this country and in fact coined the term "provider" at that time and what the brochures said essentially was that he knew that we were all pretty much crooks. Then the brochure listed a series of things that they were going to catch us doing, meaning that this is what they were investigating and then the last page of the brochure had a little [barbed wire] that said, "If you're one of the few honest ones, use an 800 number, turn in a friend as a bounty." I'm not the only one who remembers this, correct? I put that piece of paper on my desk and stared at it everyday for three months when I was relatively new in practice. I've been in practice for only six years at that point and then after looking at that piece of paper everyday for three months, I said, "You know, this is not what I signed on for" and I decided that I would never file another Medicare piece of paper. Now, of course, that was illegal in 1984. If you saw a Medicare patient in 1984, you had to file the papers so what

I did as sort of a sideline was I treated all my Medicare patients for free from 1984 until 1998 when it became legal to opt out. I was told that I could be prosecuted even for doing that. I figured I would take my chances if the government prosecuted me for treating people for free. The other thing I'd like to say about Medicare is that for practical - in real terms, Medicare reimbursements for doctors have been pretty much cut every year since the program was instituted. What's happened over that period of time is that there has been the same explosion in Medicare cost just as we have seen everywhere else which, of course, points up the folly of trying to control the total expenditures by price controls. You cannot do it that way.

Betsy McCaughey: So one of the issues that's in the headlines almost everyday is the public option, a third public program that according to most of the bills currently in the legislature would reimburse physicians and hospitals at the Medicare rate or slightly above the Medicare rate during the first few years and then at the Medicare rate. So what are the thoughts here about that, Dr. Moses?

Dr. Jeffrey Moses: Just one thought going back to Medicare. I mean you're all talking back to the dark days when the AMA said the Medicare was going to be socialized medicine. Interestingly, my public health professor [then] sat at [Collin's] right hand writing the legislation under Lyndon Johnson and he shared with us at that time was that that was the intent. The intent was to start with the elderly, run up cost, make it so expensive that there would be [union cried] to contain cost and expand this. It was only twenty years after Truman proposed it. Same guys were around. So I mean I'm not - the only - it was then executed. It doesn't mean it wasn't the intent. There's no question that the public option is the same idea. The fact that they can dictate specifics of the plans and have tax subsidies which of course they'll have ultimately, and really made the rules impossible for private insurers and that's why I think the left is so hell-bound to have that in because they know this is the foot in the door and anyone who thinks otherwise, is not - I'd really like to sit down with Senator Schumer, have that discussion with him because I think he's being a little naive.

Betsy McCaughey: Dr. McNelis?

Dr. John McNelis: Yes. I don't think it's a foot in the door. I think it's the hammer. It's the next blow. I think Medicare was the foot in the door. Actually, I have some slides on them [unintelligible]. You can see that it's the [price] that's developed over the past four years. Well, my feeling of the public health option is it's designed to replace Medicare. Maybe not in one or two years but over 20 or 30 years and everyone's going to be on it including the elderly and that's going to lead to some problems specifically in payment because I think part of the public health option is you have to pay into it.

Betsy McCaughey: Yes, Dr. Fields?

Dr. David Fields: I'm going to step out of character here. I think we need a public option but I think that the way - and this in my slide so I'm going to preempt my [slide] a bit here. The way we need to do a public option is totally different for the way everyone's been thinking about it. Everyone thinks of a private option and a public option standing side-by-side and competing with each other in the public option is going to keep the private options honest. I think that that's really the wrong way to do it. I think what we need to do is to rotate the picture 90 degrees so that the public option underlies the private option and the public option applies to everyone in the country, not just the poor. What it does is it provides you with one of two things. It provides you either with totally free, no deductible, no copayment, no charged care at any public option facility or if you want to go to a non-public option facility, it provides you with some not-very-great but some first-layer insurance coverage that is based not on usual customary nonsense but based on some specific fee schedule for, in these days, every procedure in the CPT code book. You cannot file an insurance claim without something in the CPT code book and the CPT code book as I'll mention when I get to it, I think can be our salvation as long as we get what's [crosstalk]...

Betsy McCaughey: Translate that to what ordinary people understand.

Dr. David Fields: The CPT code stands for Current Procedural Terminology, anything any doctor or any hospital does to any patient has a number. If the number is specific for the operation, the procedure, the office visit, the laboratory test, something and every CPT code has some value assigned by some insurance company to it and every doctor picks some number and charges some amount for that CPT code.

Betsy McCaughey: Dr. Guillory, didn't you have something in mind like this as well?

Dr. Samuel Guillory: No. We discussed having a program we have underlined where every patient in the United States would be given a healthcare card at the beginning of the year like a social security. Everyone in the United States would have one and the government could either assign a - there are statistics to show what's cost for healthcare by age groups and you can assign them to it. I think we are confusing two things I think in the legislative body. We're talking about healthcare insurance and healthcare and those things need to these. I have no problem with the government - our government, our social security system providing that everyone has a way to pay for their healthcare. That's what happened in 1965. Only half of the senior citizens had any access to healthcare because they had no way to pay for it. So they came up with a system to go from people not having a way to pay to give to a physician. The problem is, is that the healthcare insurance, the provider is now trying to dictate what happens on the healthcare side.

Betsy McCaughey: What the doctor actually does.

Dr. Samuel Guillory: What the doctor provides, what the [government] provides and that's the problem. That would be the same as saying that an insurance company that insures a car tells you how the car should be made and how it should be repaired. They don't tell you that. They only say, "We'll provide this to do it." I think the discussion is always on health insurance. We're not talking about providing healthcare for patients in this country and that's the difference. I'm in favor of us having a way to have everyone have a way to pay so they can enter the healthcare system. What I'm not in favor of is what doctors were afraid of in 1963 and 1964 is that once that it became this way for the government to

provide healthcare, they would then start to infringe on how the care was provided.

Betsy McCaughey: Despite assurances in the 1965 law that they would not...

Dr. Samuel Guillory: Despite the assurances and here we are, 40-some years later they've done exactly and they [unintelligible] practicing that sees what they argued against, it has come true.

Betsy McCaughey: Dr. McNelis?

Dr. John McNelis: That's exactly what they want. I think that the people - MedPAC could come out and set it. Certain members of Congress could come out and set it to our money. We want accountability. The buzz words are "bang for the buck," "accountability and..."

Betsy McCaughey: Pay for performance.

Dr. John McNelis: We've heard them all. That's exactly what they want and honestly, I can't blame them. If they're putting the expenditures and whoever's paying has a right to expect they're getting what they're paying for. Around this, we've turned the power of the first over to the government and we will continue to.

Betsy McCaughey: Yes, Dr. Pfeifer?

Dr. Tracy Pfeifer: I just think that using Medicare as an example of what could be done for patients is really very illusionary. There's at least \$30 trillion of unfunded future liabilities for Medicare and up to 50% of Medicare patients have a supplemental insurance policy. So adopting some type of Medicare type of system for the currently uninsured, I think is something that in the long-term is not going to work.

Betsy McCaughey: Yes, doctor?

Dr. Richard Amerling: Some people are losing track of that is that this debate we're getting into the arcana and the details of insurance policies. That's not what

it's about really. It's about the role of government in our lives and if you accept a government role to provide healthcare then they're going to be in our face telling us how to provide healthcare. It's really about liberty and it's about individual liberty to buy healthcare and find the doctor that you think is best and keep the government out of this. This is not an insurance debate. It's really about our own personal liberty as physicians and about patient's liberty.

Betsy McCaughey: Well perhaps one thing that we could discuss and I see all the hands coming up. We want to make sure that people who are too poor are provided with healthcare. I think everybody who are on the table and many of you provided a lot of free healthcare because of your commitment to do that. What should everybody have to be in the system where the government is somewhat defining or more and more defining what the doctor can provide for the patient. Yes?

Dr. David Fields: I agree with Dr. Amerling completely. It's about liberty. As a matter of fact, the first time I formulated the theories was in 1992 when I was in law school and I wrote in paper called Truth, Justice, the American Way in Healthcare. Well, two things, number one, you Betsy have mentioned twice that there are assurances in the Medicare and Medicaid laws that the government and not meddle in healthcare. The problem with those laws is that the language is not in the bill proper, it's in the preamble. It's an expression of goodwill and has no legal force and I think that any law that commits the government in some way to financing healthcare has to include in the body of the bill, it says, "This cannot be changed without a super majority of both Congress, of the Senate and House overriding this particular concept" and what I'm going to propose is that the government funds healthcare but government has nothing to do with either of the actual payment or the actual administration of healthcare.

Dr. John McNelis: Why should they [crosstalk]?

Betsy McCaughey: There hasn't been any...

Dr. David Fields: Because somebody's got to.

Betsy McCaughey: ...any discussion yet of the Cantwell Amendment that was added to the Baucus plan before it was approved and sent to the Senate leaders. The Cantwell Amendment which very explicitly states that in the future, Medicare will not be on a fee-for-service basis anymore, that the Secretary of Health and Human Services will now have the power rather broadly define power to determine how physicians are paid based on the secretary's notion of what is quality and cost-effective care. I wondered before we go on if anybody wants to comment on that since it does seem to be such a radical change, unprecedented change in Medicare.

Dr. John McNelis: I don't think it's going to be much of an issue. They think all doctors are going to quit?

Dr. Seymour Cohen: I don't think anyone's going to - people are just not going to go with the healthcare when you know the government can just turn [around] anything and decide, "Hello, we're not paying you. We're not doing this and you have no freedom with your patients."

Dr. Jeffrey Moses: Well, I think we'll always have doctors. The question is who will become them?

Dr. John McNelis: I think that's just only phasing out Medicare which I think is part of the game plan and that's some [unintelligible].

Betsy McCaughey: Go ahead, Dr. McNelis.

Dr. John McNelis: [Crosstalk] and a lot of this have been already on it too so if excuse me if I'm repetitious. I feel a little bit like Ralph Kramden. I can't run to play golf and what I have [to do is] going to take me at least a week. So that alone is going to take them as the Medicare. We already discussed this. It was during the late '50s, rolled out in '65 when mean life expectancy was 68 so they figure they just pay the poor guy for three years then we drop dead. Wouldn't cost as much. In many ways, I think it's been pointed out during the course of this conversation, it is to some degree a victim of his own success. We've talked about this

before A, B and C. As you can see, the Medicare financing - if you want these slides I can email them to you, all kinds of different ways of paying for it including \$205 billion from a payroll tax, \$164 billion general revenues. Just want a simpler breakdown, 2% or 3%, about a third, comes from general tax revenues. Employers and employees, 30% Medicare, we're paying for. Beneficiary premiums, 27% and then about 10% other stuff. For the Medicaid or the non-Medicare group, as you can see, most of them are employee-based as of 2004. Only about 17.8% are insured. This [unintelligible] class, we've got uninsured group. They think they're too healthy for insurance. Only about 13.4% are Medicare and there's a smaller so private. The problem is that general tax revenues is a source of financing. Instead we are growing in our deficits spending. We're rapidly rising Medicare spending and that 45% trigger - I won't go into it because it's has been repealed. It's supposed to - which was Clinton in 2003 sort of limit Medicare spending was repealed so we got a situation like this now. With 2012, I think we're supposed to hit that 45% trigger, 45% almost [managers]. Now, we're going to be in the situation, deficit spending and it just - and if you want a graph - this is based on - and this to me is the heart of the problem. This is what we've turned over. This here is the interest of national debt. These are 2005 and these numbers are growing at a faster rate now and in the next - that was in beginning of the year, there was - this slide's already out of date and right now, it's way out of date. Then we have social security spending, Medicare/Medicaid and all under discretionary spending is a 2005, we were [deficit] spending. We couldn't cover all the discretionary spending. By 2015, we're going to be on real suit. 2030, we're not going to make Medicare/Medicaid. I think we already passed that but - and then by 2040, it was projected that we wouldn't be able to cover anything, just in the interest of national debt and some Medicare/Medicaid. So that sort of served as the macroeconomic basis for the reform. What they wanted to do is they wanted to replace all this. Now, if you think about it, you're like, "Well, now you're going to have a public option on top of this?" Right? Or you're going to replace this one with public option? It doesn't matter. It's a zero sum. You haven't really done anything unless you eliminate and knock this down significantly or you erase the taxes and even that's not going to help you too much. You're

still going to be in this soup. These figures, by the way, are from the Government Accountability Office. I didn't make them up.

Betsy McCaughey: Good.

Dr. John McNelis: It's on You Tube, right? Here, you got, it's on the [internet]. It's got to be right. All right, solutions, there are all kinds of solutions being proposed, employers and [call it], workers as source of funding. Well, they can't make it. They're already worried tax [to death]. I mean you can tax them a millionaire's tax or what I call the poor millionaire's tax which then [knocks] some 50% and makes them an eighth of a millionaire and be moving toward \$50,000.00 but then they're not enough and really make a significant difference and if you tax everyone across the board, now you're going to have problems with putting businesses. Small businesses are going to be hurting and you are going to lose a lot of productivity. Here's the other problem. I mentioned there, is that we have the demographics and the elderly population is going fast through the markers. This was [unintelligible] in '66. There are five youngsters, [unintelligible] and then we're about here with the 3.9 of 165 and then 230 at the most so it's going to be over 65 by then but it'd only be 2.4. I think two of them are my kids so that didn't do me any good. Solutions, put Medicare age back. Doesn't work. Just look at - they pushed the Medicare age back to 70. They're going to lose those premiums as I said about 29% of premiums, we're going to lose those so that's not a solution. Well, the double-dipping is probably reasonable solution if you want to save Medicare. I don't think that's the plan here but if you were, you could delay Medicare benefits to those who are employed. I think a lot of people there were staying employed well into their 70s, leave in their 80s and if they're working and they have insurance [to] work, we can continue that but I think that's obviously going to be a threat.

Betsy McCaughey: Actually the current bills do just the opposite. They provide Medicare like benefits to early retirees.

Dr. John McNelis: Right. That goes to the next one, if we could which change forward, alternative public option. There'd be more money from copays. It's a

mixed model but there's a problem right now, Medicare can't accommodate existing members so we're not going to be able to accommodate those people that we - at 62. Payment issues, the problem is that there's a thought out there that the fee-for-service pays for quantity regardless of quality and that we're paying for volume. Often you have problems. We have the hospital and the physicians working at these incentives. [These] are things that are probably bitter identified in the government that as possible problems so what are their solutions? Link payments of quality and outcomes, align the incentives with hospitals, [unintelligible] go to your pay for performance and your negative events. By the way, negative events, you wish you had guidelines because if a [decubitus] comes in and you show that you did everything right, too bad.

Betsy McCaughey: It's very interesting to see that so many people tonight have brought forward proposals some of which we've seen and some which we will see but one of the fundamental questions is, is it the responsibility of physicians to solve this macroeconomic problems or is the greater duty of the physician to protect doctor-patient relationship in the provision of care and let others discuss these issues?

Dr. John McNelis: I believe that the physicians, it's our duty obviously as a surgeon [to have a] very, very personal one-to-one relationship but we have to be aware of what's going on. I don't use the word "enemy" but we have to know what the other side is thinking, what they're planning and why they're coming out at you or where their rationale is. In many ways, they [don't cut the] [unintelligible]. They only say we get paid too much. One that they're probably contemplating is a 22% cut. Well, what are you thinking again? Simple economics is going to tell you on a micro level which is our business, what are you going to do if you get a 22% cut? You can increase your volume by 22% and what does that mean? Maybe it's more across the board so just the thought of cutting a doctor's 22% as going to somehow decrease cost could be a very fallacious bit of logic because what you're going to do - and I know you've seen this through the years - it's just going to increase your [unintelligible]. What does that mean? That means decreased quality, decreased patient satisfaction. You get people doing procedures that

maybe they should've waited long but they need to continue cost and to me, maybe this argument is moot. Maybe we're just rearranging deck chairs on the Titanic because we're fighting over limited resources. Part of this is because the government - I heard today that the Canadian dollar has caught up to us. [Currently], that's bad.

Dr. Richard Amerling: They passed us. It's a [unintelligible] but that's [unintelligible]...

Betsy McCaughey: As these five bills get pushed through Congress and combined in a joint House bill and then a joint Senate bill, what do you think the role of the physician should be? We're speaking out; we're trying to provide a voice for physicians here. Dr. Guillory has suggested that doctors make it clear that there are some circumstances under which they're unwilling to practice. What do you think?

Dr. John McNelis: We should be saying [we made this hell] and we won't take it anymore. This is not about us really; it's about what we do and who we do it for, but that's all I have to say.

Betsy McCaughey: I want you to just invite Dr. Rosenblatt to say something because I promised him that we would have a couple of minutes devoted to tort reform tonight, even though it's more discussed as something that's missing in the legislation than many of the other issues we've discussed. Do you wanted to say a few words about that?

Dr. William Rosenblatt: Yes. I think that one of the main ways that tort reform can help us, it can decrease cost. We're talking about trying to decrease costs over forgetting about a major cost in medicine today which is defensive medicine. People order extra tests all the time just so they don't get sued. Right now, in the United States, we only have seven stable states - Louisiana, Indiana, New Mexico, Colorado, Wisconsin, California, and now Texas. They've had tort reform. The states are stable. Physician populations are growing. New York, we have an issue. We're never going to get tort reform here because one of our leaders has told us. It won't happen. Unfortunately, tort reform is something that's on a state basis, so it's hard for the federal government to do it but they could put in medical [quirks] and there

are other systems that they can do. Seventy percent of all suits that come disappear and when a doctor goes to trial, they win 80% of the time so it tells you that there's something wrong with the system.

Betsy McCaughey: Dr. Steven Safyer at Montefiore - he's the President of the Montefiore Hospital in the Bronx - estimates that malpractice premiums add about 5% of the cost of his hospital and defensive medicine adds about another 5%; 10% in all.

Dr. William Rosenblatt: That's right, and if you look at certain states, in Florida, 100% of all cardiothoracic surgeons have been sued. Does that mean they're all bad? A 100% of general surgeons also. Just briefly, something really does need to be done. We want the injured patient to be taken cared of. That's not the issue. The system just doesn't work because by the time they get around to finishing, they could be dead. It's so long getting through the process, so we want the injured patient to be taken cared of. Fine; society agrees with that. Put in a neurologically-impaired [unintelligible]. Put in a compensation pool, like workers comp, happen. The thing is you have to take the lottery out of it and the lottery is pain and suffering. You can figure out what it will cost to take care of somebody for the rest of their life. No one knows what pain and suffering is and one jury says one thing; another jury says another.

Dr. John McNelis: Yes. Dr. Rosenblatt made some very good points and I agree with him. I just want to add two things. One, the cost of defensive medicine maybe costs 50 billion to 100 billion a year, and I can send you the reference if you don't believe me. The second thing, this goes to the macro versus the micro, understanding the difference. You hear a lot of people say, "Ah, tort reform and lower cost are just a minor fraction of total healthcare expenditures." That's true. If you look at that graph that I showed you before, yes, it's more comparison than Medicare and the gross national product but for a micro level in our individual practices, it is a debilitating cost. It is driving people out of business. I don't see doctors starving and I'll say, "Well, you know what? You don't see them. They're disappearing. They go to retirement early and they're doing all [unintelligible]." I don't want

one surgeon to quit because yes, they make a mortgage payment or malpractice. She's doing all [unintelligible].

Betsy McCaughey: Dr. Amerling?

Dr. Richard Amerling: Dr. McNelis, I love your point about the volume changes and the reimbursement changes. I actually have data published in an article on this in the 90s and in fact, when you cut physician reimbursement, the years immediately following that, the volume does go up and the total expenses go up. This is reproducible. Every time they have physician fee cuts, this happens so this is exactly true. With the malpractice reform, everybody agrees with this. There's no question about it. The problem is that with the current administration and Congress, there isn't a prayer that we're going to get it. This is the real issue. We have to - as a group of doctors - make a line in the sand and let the administration know that we are not going to be government doctors fundamentally. We're going to be private individual doctors. We're not going to go along with the Obama care version, whatever it is. Whatever comes out of this administration is going to be something that I think will be unacceptable to an ethical position. I want to put in a plug for the AAPS - the Association of American Physicians and Surgeons - who really is the only doctors' organization who has consistently fought this fight. I want you to all visit the website - [aapsonline](http://aapsonline) - and sign the Physician Declaration of Independence.

Betsy McCaughey: With the exception of Dr. Marc Siegel who unfortunately had to leave - there was a death in his family - I haven't seen a physician write about some of the specific provisions in the current legislation that will have such an immediate impact on the doctor-patient relationship. For example, on the Balkus plan, there's a provision that each year doctors who land in the 90<sup>th</sup> percentile or above on what they spend on patients under Medicare compared with national averages will automatically be penalized. I can imagine instances in which physicians will be worried. "Should I choose between my patient and avoiding the penalty?" I just wondered what you thought the strategy should be at this point to communicate with decision-makers in

Washington about the impact of these blunt instruments as ways to control cost.

Dr. William Rosenblatt: We could draw a parallel between the medical and legal professions, which is always fun. In this particular case, the parallel would involve penalizing the lawyers when they lose the case or when they spend too much money on the defense but win the case.

Betsy McCaughey: Or are there too many depositions?

Dr. William Rosenblatt: [Or they're too many depositions.] If lawyers were personally at stake for what happened to their clients, a lot of things would change and we could have managed law, too.

Betsy McCaughey: Dr. Pfeiffer?

Dr. Pfeiffer: Just in formal survey of physicians that I've spoken to, there's a limit to how much of a financial penalty each individual practitioner is going to be able to bear in order to "do the right thing", and this goes to the violation of the doctor-patient relationship and the trust that our patients need to having us. If the patient is sitting in the examination room with us and they're wondering, "Is the doctor not ordering a test for me because he's going to get penalized if he does it?" this is a major, major problem for patients and physicians alike.

Betsy McCaughey: This is exactly the kind of conflict of interest that was created with the [withhold] back in the early 1990s, something that we outlawed. Yes?

Dr. David Fields: I think that's exactly the point, exactly that the reasons being done and there's always the [unintelligible] component of it and that's what they'll always be - a top 10%.

Betsy McCaughey: Right. That's why I like to call it the race-to-the-bottom provision. Dr. Borer?

Dr. Jeffrey Borer: We're talking about this penalty as if there is some evidence that it will actually have a solitary effect and as far as I know, there is no such evidence. This is a device to cut cost.

Dr. David Fields: Exactly a level four evidence.

Dr. Jeffrey Borer: You're right. I think that that's very important. Many of the suggestions in those as I understand them are based on assumptions that have no supporting data, and so it's not really right. It's perhaps not appropriate for us to be arguing about or discussing how we should deal with these penalties. I think a more fundamental issue is do they serve a purpose? In this regard, there are statements made by professional societies about this. The American College of Cardiology has certainly weighed in on this. Each of us might write an article; I'm not sure how we'll get our work done everyday if we get to try to do that, but certainly professional societies that represent us can and should speak to these issues and point out the flaws so that a meaningful debate can [develop].

Dr. John Eck: I think that...

Betsy McCaughey: Yes? Dr. Eck?

Dr. John Eck: I think that we have to - harking back in the days of when Doctor Arthur Guett who was the head of the Nazi Health Commission had similar proposals - very interesting. Dr. Arthur Guett said that the greater good of the social framework was more important than the weak rights of the individual, and that every Nazi participating physician must understand his first responsibility was to the state and funding of healthcare. I think that when we sign on, we start the slippery slope. I think that personally as a physician that hasn't taken any insurance for many years, who basically has a for-profit and a charity, maybe this is the time I could explain a little bit of what we're doing.

There is a law that was passed in 1996 called the Federal Tort Claims Act. Bill Clinton and his troubles made it pass. It provides free

medical malpractice coverage for professionals who volunteer at free clinics. Well, basically, we'll have unlimited liability coverage with the federal government. That's currently in existence. Most doctors don't know about this law. Unlimited without a tail. Now, in my free clinic - in which I have for-profit and non-profit - my for-profit pays for my non-profit. In the free clinic, we see about 400 patients a month. We provide for all of their medicines. We see them for free. We often will even pay for hospitalizations. We set up our own 501(c)(3). We get donations from companies, from everyone. I ask the real questions that we should really be asking because otherwise, we're asking about being treated fairly and we'll all want to revolt. I think that's the wrong approach. I think what we have to do is harking back on why we became physicians in the first place. We became physicians because of the Hippocratic Oath we strongly believe in. We would take care of these people even if it were for free. Now, here's the deal. Ask yourselves some hard questions. If I'm too sick to work and cannot pay that premium, it doesn't matter if I'm insured. I'm really not covered, so no insurance plan that I know is really taking that as a consideration. Second, if I have a federal mandate which requires that I pay a penalty and I've lost my job and I'm too sick to work, will I be thrown into debtor's prison and pay for this? My handle on both insurance company and to the federal government is a plague on both your houses, and it might have worked for Arthur Guett.

What I will do is I will do charity and I have my private practice physician know that when they come to you, they may pay an extra because I'll take care of them even if they can't work, if they can't pay. The clinic has been in existence six years and I have a small recommendation to the federal government and all those people on You Tube, because I know this works. Some people say that you shouldn't let the nattering nabobs and negativity - as Spiro Agnew called them; some of you do remember him - taking the way of someone who's actually doing something, and I don't think we should. I think what we need to do is this is what's being done. This is what works and step aside; let us take over physicians, over charity. What I'm suggesting is a quid quo pro. Listen. In exchange for giving me full federal malpractice insurance, I will donate four hours a month to care

for the poor. Four hours, and I would say that to do that would essentially drop a lot of these arguments by the wayside because keep in mind, they're saying, "Well, what about the poor? What about the uninsured? What about those people who can't [pay out here]?" I'm saying, "You know something? A federally qualified clinic in Plainfield is charging \$165.00 for every patient they see and it costs me \$12.50, and that includes medicine and theirs is not."

Betsy McCaughey: Well, that's really interesting. Dr. Kassimir, what do you think?

Dr. Joel Kassimir: As far as funding or...?

Betsy McCaughey: Yes. Well, you came with a vision of reform. How does it compare with this one?

Dr. Joel Kassimir: Well, mine addressed certain issues that patients - oh, I'm sorry. I was going to speak about this in my presentation which is coming up next and I'll expand on it when I do so. It seems that the two greatest concerns regardless of patient's background - whether they're billionaires or pro bono - is the cost of medication and more catastrophic illnesses. They want to go in knowing that they're not going to be lied before more than a certain amount of money. When I give you my presentation, I'll expand on it shortly.

Betsy McCaughey: Okay.

Dr. Richard Amerling: I do have an answer for the Medicare. If we were to give all pharmaceutical houses to donate 10% of their medication to free healthcare centers, [FDA] insurance so once you pass a certain level of the federal government, they put the seal on it and they might as well insure it, have the federal government insure. You will see the cost of prescriptions significantly drop - Vioxx is an example. I'm an [unintelligible] pharmacist. I was in surgery for thirteen years and then I went into family medicine, so I've done many years of training and I understand all these issues. On this day, I feel that we can. The hospitals would benefit from this. How many needless admissions because we're fearful of that CAT scan that we didn't do? How many

of those admissions would be dropped? How many of those [pre-cared] [unintelligible] would be eliminated? That's our [corollary] of strength and we need to hold the public and say, "This is our part in the care. We care in exchange for our performance."

Betsy McCaughey: It's very interesting. I just want to ask Dr. Hurley because he practices in an intercity public hospital. Would this work in your area?

Dr. Matthew Hurley: I just like to say a dear colleague of mine had quoted a phrase - and I read it all the time - that for the last several thousand years, you had doctors and you had patients and everybody wants to get a piece of that relationship. It will exist for the next hundred years and in that context, coming from a city hospital where I in part work for the government but Columbia gets paid and they pay us - I moved in [unintelligible] whose patient population is about 30% uninsured. The more I do and understand guidelines and whatever, the more my hospital goes down, too, because the more I do, it increases the deficit, even though it could be right. I think that to address two issues: one, I hope that whatever takes shape out of the five bills, that Congress doesn't give the safety net hospitals a short trip that in some way we maintain our dish money and [UPL,] etc. to try to preserve the service that will exist, regardless of what shapes out. We will always have some degree of uninsured that we would have to address fundamentally we care and some doctors will do that. In addition, I'm one of the few several thousand physicians who believe in a single-payer model, the Physicians for National Health Insurance. I know that that is not politically the wind at this particular point, but I do believe that there should be at least some public option to capture the base, at least for some preventative services for the poor and the [desolate].

Betsy McCaughey: I want to ask you one question about that because here we are in New York and we know that in New York, the hospitals are very concerned. Right now, Medicare pays 94 cents for every dollar of care delivered on average. Medicaid, about 86 cents. The reason our hospitals are able to keep their doors open is that they squeeze \$1.32 out of the private insurers to keep things going, and we see that Medicare is going to see a 30% increase in enrolment. We see that Medicaid is going to add

about 11 million people. You see that private wedge shrinking and then if we have a public option, the private wedge gets even smaller. My question is if there's a public option that pays hospitals at the Medicare rate which is shortchanging them, how is your hospital going to keep its doors open? Wouldn't it be the knockout punch for your hospital?

Dr. Matthew Hurley: It would be tough but I would always see that there would be a need for a safety net hospital regardless because the private hospitals are not going to pick up the slack. Where the money ultimately comes from, I don't know. I would say that we need strong safety net hospitals within both the intercity and rural communities throughout the country. We may have many who are poor, some uninsured because they are undocumented and we don't want to address that, but we need to have safety net hospitals that pick up the slack; however it's funded by the city, by the state federal government.

Betsy McCaughey: I have a commitment here to two people who haven't presented, even though our time is getting very late - Dr. Kassimir and then Dr. Fields.

Dr. Joel Kassimir: Well, I'm going to try to simplify because we've heard so much interesting information and I don't know of the - as the President likes to say - the folks viewing You Tube how much there is they really going to absorb. They basically want to know a couple of things and I'll try to address those very simply.

Thirty years ago, Ted Kennedy spoke at my medical school graduation and it was at that time that I became aware of his efforts to nationalize healthcare. It was frightening then; it's more frightening now. Earlier this year, I had the opportunity to spend several hours with Prime Minister Tony Blair, at which time I commented to him that for some reason, Americans have the notion that England and other countries like it had the answer to healthcare, especially since Michael Moore's movie. He responded - the Prime Minister - by saying, "Joel, we so don't have the answer to healthcare. What we have is slightly better than nothing at an enormous unaffordable expense which won't last forever." This is from the Prime Minister himself who had ten

years to ruminate about this. He also offered to arrange a meeting with me and his healthcare minister, hoping that America could avoid the mistakes that Great Britain had. I actually called the hotline to the White House which is available to every person in this country, and for those who want to call, it's (202) 456-1111. Though the women on the other end of the call accepting on behalf of the White House generally seemed interested in what I had to say, they said, "Wow! That's a good idea. Where did you get that?" Well, I made it up. I never was sure if it would have any impact and I would call back very often. However, I did take the opportunity just as an aside to tell her - and hopefully the administration - how to get at least half of the 25 million unemployed Americans back to work. I [unintelligible] [that in] during the healthcare. Very simply, here we are facing 10% of our country that's unemployed and it's probably a lot more than that because a lot of them have stopped looking. I suggested - and again, this is totally off the topic of healthcare - but it is because we have to find alternative ways of funding and get the economy going. We have no economy unless money constantly exchanges hands, and here we have 25 million people getting unemployment for a year or so. Then what they do is anyone's guess but I said to them, "Why doesn't the government offer to employers an opportunity to take one of these unemployed people and give them a dollar-for-a-dollar deduction for that one year so they could be retrained?" Though they're getting the dollar-for-a-dollar deduction, they're still paying taxes - the person who's receiving the salary - and in that way, they're paying their rent. They're paying their shopping and the money starts circulating again. I've said this to multiple politicians - our senators, congressmen - and everybody says, "Good idea," but nobody really follows up. I'm not really sure; maybe it's not in their best interest but that's just an aside to find other ways of funding. They can't go to the doctors all the time and say, "Cut your prices. Cut your prices. Cut your prices or see people for free." I'm gratified to see that everybody here - not that I was surprised - does quite a bit of pro bono work which I think the government completely overlooks.

Anyway, I subsequently made follow-up calls to Senator Schumer who not only would take my call all the time previously and would call my

office often in search of contributions to the Democratic Party but when he knew that I wanted to speak about something that he wasn't in quite agreement with, he had his healthcare expert speak to me. That was unkind. She was a very lovely girl and I said to her very politely, "How old are you? Have you ever been to the hospital? Have you ever been sick? Do you take any medications? Do you take statins? Do you take anything?" Of course, she was a young, ambitious gal and very kind and intelligent but not really experienced in these matters.

Anyway, the reason for me being here today is not the fluttery one with more statistics that can easily be adjusted - as somewhat suggested by a good mathematician - but rather it was to present a few ideas for your consideration - as they say in Hollywood - but I believe it would have a very positive effect on both the quality and the cost of healthcare in this country. Unlike many physicians advising the President, I actually do see patients everyday. I write prescriptions for them everyday and I ask them what it is they really want. These are people - as I mentioned before - from very diverse backgrounds, from billionaires again to pro bono patients. Interestingly, their first concern is the cost of medication. They take their pills everyday when they have them. They do not go to the doctor everyday. Most see their doctors once a year unless they're very ill and I'll see them more frequently for a short period of time. In the 34 years since entering medicine, we've witnessed outrageous advancements. Medications that not only improve the quality of our lives, prolong our lives, and keep us out of the hospital whether it's for surgical or medical reasons. I can recall when patients with ulcers that didn't respond to antacids would be subjected to the more extreme subtotal gastrectomy, which is largely a footnote in medical history. When my mentor, James Black, created the first H2 receptor blocker, Tagamet, there was no reason really for many general surgeons to even learn the operation except for special situations.

I say to those on You Tube who are listening, please don't be offended when I say that there are few physicians, few lawyers, few politicians, and fewer bankers who are as important to the quality of our lives in many ways next to the [unintelligible] at the pharmaceutical industry.

Like it or not, it is no accident that our life expectancy in this country is by far the greatest in the world, albeit at the greatest cost. I recently wrote a prescription for a patient with cystic acne. The cost of this medication in New York was \$800.00 for a one-month prescription out of a five-month course. In Monaco where this patient happens to live - she left Japan when the taxes got too high; it got up to 78% which is what we're looking at eventually - she left, went to Monaco, and said the same prescription costs nineteen Euros, not \$800.00. Having said this and, again, for your consideration, I believe that one way to bring down healthcare cost and improve the quality at the same time would be to change the patent laws on pharmaceutical companies. Companies were awarded a seventeen-year patent. I think it's twenty years now. From all the data that I could put together - that's again from the date of submission which most people don't realize, not the date it comes out, so again the moment that the compound is created. So again, this is prior - to the sake of people listening - prior to phase I, phase II, and phase III of clinical trials and it takes an average of about thirteen years for approval if it is to be approved at all, in spite of the amount of money that was put into the research. Basically, seven years to recoup the investment, make a profit, answer to shareholders, and begin and continue the search of new drugs at enormous costs. Patients would still have to wait seven years before the drug is off patent and able to purchase it at generic prices, which is usually somewhere between a third and a quarter of the price of the brand drug, and I feel that this is inexcusable. People with the most limited resources, as well as those more fortunate, should have access to the best drug at the most reasonable cost as soon as it becomes available, and this surely will cut down the cost of medication and keep people out of hospitals.

The paradigm in America has largely changed to a Wal-Mart culture; like that or not either. People want quality; they want name brand products at reasonable prices, and I don't have a financial interest in Wal-Mart. By extending these patents to another twenty, 40, 60, or even a lifetime patent, we can negotiate with manufacturers for prices that would make generics seem costly. I know they would be willing to do so. I had this conversation with Senator Schumer. About a few

years ago, he was my dinner partner and he says, "That's a great idea. Here's my hotline number. Call me whenever you have another idea." He didn't follow up on it and I can only imagine why. Perhaps it's not Senator Schumer; it's not the senators who have a conflict based on who is supporting them for election.

Betsy McCaughey: Before you go on, let me just ask this. It's such an interesting proposal. Is there anybody at this table who would oppose lengthening patent life in return for the obvious reduction of the cost of pharmaceuticals?

Dr. Richard Amerling: Patents say my idea is brilliant. [Laughter] What really is it's inspired. It's counterintuitive but I think it would work. The other thing that it would do is it would free up the pharmaceutical companies from making copy on me-too type drugs that don't change the fundamental characteristics of the drug and don't add much value, but it's simply a way to extend patent protection or through the same molecule.

Betsy McCaughey: Yes. It's counterintuitive but it would really work.

Dr. Joel Kassimir: Well, the drug I mentioned before, Accutane, which in spite of all the press that you've read about in the last 25 years, has dramatically changed the lives of kids with conglobate cystic acne in a really meaningful way. It was almost like the creation of prednisone for other diseases. I was heartbroken when they took it off - when Roche stopped making it - because it was competing with very, very inexpensive generics. I'm sure if we had negotiated with Roche at the time that they would've come out with cheaper than generic prices just to keep it going for an infinite amount of time. I won't even get it into the discussion; that's for another forum as to the comparison between generic and brand drugs.

Dr. Jeffrey Moses: Well, the drug companies go along with this because after a few years, they get a replaced drug very often - at least in my field - and they would rather make the profit for seven years because by seven years, there may be another drug and they'll be out of the [unintelligible].

Betsy McCaughey: That's a very interesting point. In other words, in fields where the pace of innovation is so rapid, how meaningful is a lifetime patent?

Dr. Joel Kassimir: I think the lifetime patent is very meaningful. When I look back and see the drugs that I used in medical school, there are very, very few that are left, but it provides them that safety net also that they don't have to gouge for seven years. I guess we can do a study and see what drugs have been around 50 years or which ones we're still using. Of course, we're still using...

Dr. Jeffrey Moses: Well, the question really is [unintelligible] derivative?

Dr. Joel Kassimir: Yes, I think they would and Senator Schumer said he was going to follow up by calling some of those companies. I did call some of those professionals and each and everyone said that they would go along with it because it gave them a much longer horizon to recoup their investments. Yes?

Betsy McCaughey: Dr. Fields? Oh, I'm sorry. Go ahead.

Dr. David Fields: That's actually very good. My only question goes how would you establish a fair market value to be? A fair market value could be considerable and be subject to some circumstances to be jacked up considerably [unintelligible] cost, marketing cost, all of those other [unintelligible] costs.

Dr. Joel Kassimir: I guess it's a drug-by-drug situation and I guess we could commission a study. We could figure it out and we could sit with the CEOs but they do have to answer to the shareholders. As Dr. Cohen said before, it's outrageous that you'll be spending \$5,000.00 a month out of pocket for a new cancer drug but many of the old - I'm not familiar with exactly which drugs in your field are changing and which ones are still being used. I know that there are still many, many that have been [unintelligible]...

Dr. Jeffrey Moses: Well, for example, the [unintelligible] drug. There's one now by [unintelligible] that would compete against its - certainly, they've been

out seven years and now, they would've lost [unintelligible]. Of course, the company has changed but...

Dr. Richard Amerling: Why should the FDA insure something they have certified? Why are the pharmaceuticals...?

Dr. Jeffrey Moses: If another pharmaceutical company comes up with a similar drug that may be slightly more efficacious, you're going to start buying that one and they've only sold for three or four years. If they've sold in a lower price for those three or four years, they've really lost money in all fairness to them. If they were able to charge a lot for those three years, at least they make that their investment and by seven years, they made a massive profit. It's a real dilemma.

Dr. David Fields: It would stimulate more creative research. They wouldn't be looking through a margin [unintelligible] drug.

Dr. Jeffrey Moses: [Unintelligible] [a simple] drug, right.

Dr. David Fields: They would make something profoundly different which will find its own market.

Betsy McCaughey: I want to ask you one more question about the drug issue before we move on and hear Dr. Fields' proposal because the evening is getting late. Dr. Ezekiel Emmanuel, one of the advisers to the President, has written that the federal government reimburses too freely for cancer drugs rather than requiring that there is a larger percentage of responsiveness to the drug. There are a larger number of patients who respond to the drug and I know that many of you have been involved in looking at drugs that work for some patients but not for most patients, and I wondered if you could comment on this.

Dr. Jeffrey Borer: I can't talk about drugs for cancer but I've been an FDA adviser for 32 years and there's no question that for most drugs in my field, in cardiovascular medicine, there are very good ones. Seventy-five percent of people will respond; 25% of people won't. It's just the argument in favor of having multiple different though similar

formulations. That is what I call [classes of the poor term]. I think the issue here though is how good is good enough? If we have a certain standard of care and certain expectations now, is that good enough? I think that in many ways, what we're hearing from the President's medical advisers is that what we have is good enough and we really shouldn't be wanting or expecting anymore. I think that Dr. Kassimir made a very important point, many very important points, but an important point about the amount of time that it takes for a drug to reach approval if it's approved at all. I think - with all due respect - it's not true that drug companies spend much of their capital attempting to develop me-too drugs. I don't think that's true. I think there are hundreds and hundreds and hundreds of compounds that are being explored everyday by many drug companies. It's just the most [unintelligible] work.

Dr. Joel Kassimir:

I'll try to wrap this up quickly. There's no reason that my statin should cost \$4.00 a pill. It should cost 40 cents at best and what they're doing in India, it could cost 4 cents if they're doing the volume. Again, I just want to reiterate; this is the patient's greatest concern which surprised me. Anyway, the next issue was catastrophic insurance and to have that net which I have mentioned before based on the ability of the patient to pay or not. I do believe that we can come up with an algorithm that could be created that would assist Americans in determining what their actual risk tolerance was. To know that your out-of-pocket expenses would not exceed a specified number, I think is comfortable and sensible. I don't think we should micro manage the visit to the doctor. It's the more important macro issues - as Dr. McNelis was saying - with the macro issues that they're concerned about. They're really not concerned about a visit a year to the physician. This is particularly important not for the Medicare patients; they're covered, and the Medicaid patients are covered but this is for the millions - the 12 million people, not the 47 million people that everyone keeps quoting but the 12 million people who are working, whose employers did not provide healthcare, and who are not able to afford an outrageously expensive individual policy. I think this government needs to focus - and as they say on Wall Street - let's trounce them off and let's take care of them first. You get a

reasonable medical pharmaceuticals and a net, and I think we've made an impact. I think the reason so many healthcare bills have failed in the future is they were so wide-encompassing and we have to do something more conservative and see if it works and then move on. Betsy says that the original healthcare bill - which was 1,018 pages, and of course, I think you said four other versions. There are five now being debated, and I'm sure the President and the Congress realize that once any measures are enacted, it's going to be very difficult, if not impossible, to undo it unless there's economic catastrophe in this country. We all well know that there is no real way we can determine what policies today are going to cost years from now, so let's keep it simple. I am told that social security was off by a hundredfold and I believe that when I see your slides, there's only two people paying in - I understand - for twelve...what is it? There used to be twelve people paying in for each one and now, there are two point something paying in for something, for one person collecting. Not to say that we shouldn't have it but we need to be reminded of its possibility. To pay for this coverage, it has been said that a 5% tax on those earning \$200,000.00 or \$250,000.00 or more is an order. A Brooklyn congressman recently said to me that he's going to raise it but regardless, this is not really attacks on the rich. They are attacks on the high wage earner, and there's a big difference. It's entirely possible for a billionaire to pay nothing when they're sitting in triple tax rebounds with some of their hedge, when the guy killing himself everyday and out there working \$60.00, \$80.00, \$100.00 a week like we do is paying that extra five, six, and who knows what that number will go to, especially when the Bush tax law expires. You can be expecting - I'm predicting over 70% of this will pass us.

Finally, for your consideration, is the amount of fraud being committed. Now, I'm aware of the fraud being committed in my particular - and it's not just doctors because we are the good guys - but there's always that small group of people that make us look bad. For example, cosmetic procedures, which I know a lot about. I sit on the advisory board, and [Unintelligible], Botox, Restylane, Perlane, Juvederm, teeth whitening, laser treatments, resurfacing, nose jobs - all of them eliminating this fraud would pay for a hell of a lot of

bypasses, angioplasties, hip replacements, knee replacements which are the foremost performed surgeries for the elderly for Medicare patients. You only need to go to a particular burrow in this great city where you have no idea how many hundreds of millions in fraud are being committed each day. On the other hand, as I said before, it's not limited to physicians. There's no reason that the former secretary of the treasury should've given a tax holiday for coming to public service. I am told - but my numbers may be wrong - but they're close. The former secretary of the treasury had \$800 million in Goldman Sachs stocks and he had about \$160-million tax liability, and they gave him a holiday and did not have to pay the \$160 million in what was owed to the government just for voting to the treasury for a short period of time like we really needed him.

Betsy McCaughey: That was great.

Dr. Joel Kassimir: [Unintelligible] pay. This is the last part, so surely it needs to be changed but it needs to be a thoughtful change, an incremental change one step at a time so we could be certain that these policies actually work to the benefit of the individuals in our country. I suggest we begin with the 12 million unemployed as I said before who had been unkindly labeled the working poor who feels safe - again, with the medication - and when medication cost would become almost trivial and again the net for relative catastrophes for pre-Medicare aged patients.

One last point, that their annual visits to physicians with parameters, of course, should just have a dollar-for-dollar write-off on their income tax. McCain did say something like this but this is a yearly visit - once a year - and to give them that once-a-year write-off, they would go and perhaps would avoid other more serious illnesses that would require hospitalization. Anyway, President Obama and Ezekiel Emmanuel who I actually met at the Aspen Institute this past June - let's say we had a lively exchange of ideas, like I would say the ideas actually went in one direction. I'm sure we still share a similar vision for healthcare in this country, but we differ on implementation. As it has been pointed out,

this country was founded by an eighteen-page document. Surely, this proposed first phase of healthcare reform can do the same.

Betsy McCaughey: Thank you.

Dr. Joel Kassimir: You're welcome.

Betsy McCaughey: Now, Dr. David Fields also has a proposal.

Dr. David Fields: I am [unintelligible].

Betsy McCaughey: Yes. Could you think he can give us a very short version of it because everybody has dedicated a lot of time to this tonight?

Dr. David Fields: I'm going to give you a very short version.

Betsy McCaughey: It has been so interesting.

Dr. David Fields: I'm going to give you a very short version. Before I give you very short version, I'd like to say two things. One is a different look at healthcare costs. Our healthcare costs will never going to be cheap. It's labor-intensive and challenge-intensive, technology-intensive, profession - and intensive is expensive. I think we need to accept that, and I'm not sure what the difference is if we spend our money on cars or flat-screen TVs or cosmetics or on healthcare. It serves the same purpose which is it recycles the money. Some [may do warrants] and pays taxes on it and it improves your quality of life. Frankly, if we make our medical care convenient enough and good enough, it would be something that we could use to reverse our balance of trade problems because the world used to come here for medical care and now, we're going to India. I think that if we looked at it from the point of view of - let's make it really good and worth it - then it might change a lot of minds about what we're doing. Now, the other thing I would like to say is that I love Dr. Eck's ideas. The only problem I have with them - although I've been doing them myself for years in a limited way - is that the concept of charity in medical care went out the door with Medicare and Medicaid because it was considered beneath human

dignity to accept charity. That's the language in the discussions behind the bill and if we could use something to restore that, I think it would be a great idea but I don't know how we're going to do that.

Okay, so I came here with a 25-minute presentation that I boiled down to eight minutes. It's cute. It is a healthcare plan to die for instead of one to die from. How do I [remove this] and I'm going to make it five minutes. Pretty much, everybody has the same objectives. We want to enable everybody to get care. We want to control cost. We want to maintain freedom of choice for patients and healthcare professionals. I think this one is under-stressed because you need to create an environment where the doctors and the patients aren't feeling abused because this is what the central core of the doctor-patient relationship is about. We also need to foster real competition for patient care in the private sector, keep costs down, and to maintain opportunities. Finally, everybody is complaining about our employers having the burden of healthcare. I think we should rescue them from this. This is a slide that contains - it's not readable. I put this slide up to say this is the sort of slide I would be using if I was going to be here for an hour and a half.

Betsy McCaughey: Very funny. What a sport!

Dr. David Fields: Alright, okay. If you want healthcare for everybody, the first thing you need is an infrastructure, alright? You need to have hospitals. You need to have doctors. You need to have physical facilities. We fortunately have the ability to create that infrastructure today with a not a lot of money. We took all of our VA hospitals, all of our federally-funded hospitals, all of our charity hospitals, all of our municipal hospitals, and all of our medical school teaching facilities who are divisions and converted them into an American-in-distress medical care system. We would have a background system that anybody could walk into with no deductible, no copay, no charge. It could be federally funded at very little money.

On top of that, we should have a private practice medical care system that anybody can pay more to get into which offers you flexibility but -

and this is kind of on the side - one of the problems with our healthcare today is the concept of the deductible. The deductible is destructive. It ferments first use of care. The copayment, on the other hand, makes everybody think about coming back and coming back and coming back. If you're in the private system, you should have mandatory copays but nobody should ever have the deductible system. If you allow patients to flip between the two systems, you allow doctors to flip between the two systems. You can have an integrated medical system.

Betsy McCaughey: Like in Britain?

Dr. David Fields: Sort of but not exactly because what Britain does is that Britain says, "If you go private, we're not going to pay at all." What we should be able to do is to go private for something, public for something; do it any way you like. This is what I said before which is that what we need is a public health plan underlying everything. It's a public health plan. It provides the first layer of coverage for anybody who wants to go private. So there's a reasonable number, not a huge number, and there's copayment on it but if you go in the system that's designed to accommodate public patients, there's no charge for anything. You walk in; you hand them your American-in-distress card, and you get taken cared of. There's no income qualification for being covered by this because if you're rich, you get your \$40.00 versus a \$300.00 doctor visit that comes out of this national system. The advantage of this is that if we're all going to fund it, we all ought to get something out of it, even if it's not all that much.

Now, the way to fund this is to have public funding. It has to be public funding. There's no way to fund the system like this otherwise, except that the public funding should not be by taxes. It should be by premiums. Premiums that are actuarially designed and designated based on accounting principles. They could be collected on a 1040 but it's not a tax when you make more money, you pay more tax. It's if you're above a certain threshold, you pay the premium. If you're below the premium, below the threshold, the government pays the premium out of general tax revenues. Now, where does all this money

go? It goes into a huge fund which is managed by the private insurance companies. The private insurance companies are in charge of disbursement. The government is out of the administration or the actual payment for medical care. They just fund it. The way the private system manages this public fund, which is the lowest layer of care financially, is they just hand money out to everybody who asked for it. It will actually work because in the private sector, you're going to have a copayment but the copayment is not going to be collected by the doctor. The copayment has to be collected by the insurance companies so the doctor can't say, "I'll take whatever the insurance company pays," so everybody has to pay something, even when they're covered. Number two, the private companies who are administrating this money gets something akin to Medicare profit, which is the 2% to 3% administration cost on top of it. Everybody says the private administration is more effective than the government and more efficient than the government. They could probably make a profit on 2% to 3%. We don't waste any money denying care because there's no concept of medically necessary. You walk into a doctor; you're willing to pay your copay, no coverage. The private insurance companies also get to sell what we call private amenities policies. The private amenities policies, however, are not based on usual and customary. They are not based on anything except the CPT code book. Everything in the CPT code has a price. Everything in the CPT code - today, you can't submit anything to an insurance company without a CPT code. What you do is you put that price online. You have websites that list every insurance company's allowance for a CPT code and their charge for a CPT code. You have a website calculator where somebody can go online and say, "I want to buy insurance from this CPT code and this CPT code and this CPT code," and this one and you push the button and they tell you how much it's going to cost you a month.

Betsy McCaughey: Yes, but this is also an overhaul?

Dr. David Fields: This is an overhaul.

Betsy McCaughey: This is an overhaul and Dr. Kassimir was just making an appeal...

Dr. David Fields: This is not incremental.

Betsy McCaughey: ...for an incremental. I know we have a lot of different ideas here. Some of them are just terrific but now, as we're closing tonight, we have to figure out what to do as we see five bills being pushed through Congress and reconciled as a way of wrapping up, whether we have a strategy to address the Congress which hasn't really listened to physicians.

Dr. David Fields: I think the answer to that is that there are some games you really simply not agree to play, and that has been the doctors' experience for the last 30 years in dealing with government healthcare. I think what the doctors have to do is come in with their own plan and say, "This is a [current] plan, okay? We're going to reform healthcare for you because we're the people who were trying to fix problems. We have spent our whole lives fixing problems. You've got a problem here and this is our solution to the problem. Forget all that nonsense; you can't [unintelligible]. It's not going to work."

Dr. Richard Amerling: I think the problem with that is that many legislators are not being supported by us as the other side is...

Dr. David Fields: We go to You Tube. We go to You Tube and we get there...

Dr. Richard Amerling: If we get there, we support it by insurance companies and pharmaceuticals when it comes to contributions, and that's not difficult. I think one thing we need to do after the legislative body is something that has not been discussed. We know that our government has three branches - with the executive branch, we know that the President is pushing the executive branch. With the legislative branch, we are sort of at war with each other right now, but one thing can be sure is if we guarantee every person in the United States some level of healthcare and the government is the ultimate [catch of that], it's going to be similar to guaranteeing every person they can have in the mail. The judicial side of the government - which hasn't come up this equation yet - we'll make sure that every system has their mail delivered, no matter how distant they are from any service. Once we

guarantee healthcare through the government thing, a patient will then have the ability to go to the judicial side and demand that they have a CAT scan within 30 miles of their house, have a right to certain surgical procedures which is going to become extremely costly. I would say that either the executive branch or the legislative branch will look at the judicial side.

Betsy McCaughey: That's a really, really interesting point.

Dr. Richard Amerling: I think that's something we should point out and we should begin to put into this equation. I think that's what the doctors - we're facing the judicial side, the legal side. We know how costly that has been. It's going to be a very, very costly event. The government cannot guarantee healthcare. It can only guarantee if they'll pay a certain amount of money.

Dr. David Fields: That's exactly right.

Dr. Richard Amerling: Look, I'd love Dr. Kassimir's ideas but the problem is you're calling the White House. You're calling Schumer. You think these people care? They don't. They don't care about the healthcare situation. They don't care about people really. They care about maintaining their power in Washington and [unintelligible]...

Dr. Joel Kassimir: Well, Senator Schumer. I would appreciate it if he would perhaps respond to this and perhaps he'll give us an audience, all fifteen of us or so, but there's a pretty good chance or rather a 50-50 chance that Harry Reid will not be reelected. Schumer, I'm sure, is more than interested in becoming the Senate Majority Leader. I think his motivation is to do as the President wants because he's not going to get that position without the President's nod. Perhaps we can get an audience with him or get an audience with Ezekiel Emmanuel who's a very testy fellow, and I'm not sure it would help but maybe the President himself. There are enough people who have the influence to arrange one of these meetings but I think in order for us to be effective, we have to speak with somebody who's in a policy-making position.

Betsy McCaughey: Well, let me make this commitment to you. This transcript will be ready in two or three days and will be up on the internet. The YouTube will be up by the end of the week and next Monday, we'll be presenting this transcript with our best efforts of the summary and a minority of you as well, two members of Congress at the Capitol. Let's hope it's a first step toward encouraging lawmakers to actually listen to the voices of physicians who treat patients everyday rather than just policymakers. One thing that Dr. Kassimir said that I just like to underscore because there have been so many interesting ideas around the table - some of them very big ideas like Dr. Fields; some of them more incremental approaches - it does seem as if one caveat that we should deliver to Congress is this - and Dr. Pfeiffer said it earlier - first, do no harm because so much is at stake right now. Unfortunately, the American medical system has been largely misrepresented, mischaracterized over the last nine months. There are people who aren't insured. There are people who were injured by hospital infections. That's my concern most of the time but if you're seriously in one of the best places to be, it's still in the United States.

We have an oncologist with us here, Dr. Cohen, and I've been looking very closely at the oncology figures. A woman in the United States who's diagnosed with breast cancer now has at least a 90% chance of surviving it. In Europe on average, less than an 80% chance. Even more impressive differences in the survivability of prostate cancer, 99.3% chance in the U.S. Almost one out of every four men in Europe who gets prostate cancer actually dies from it. It's an astounding difference. We have a lot to protect, even though we also have many areas where we can make an improvement. Most of all - and this is what Dr. Moses and Dr. Borer were hitting at earlier in the evening - the pace of innovation here is so remarkable. We've seen it in cardiovascular disease. Since 1950, the U.S. has won more Nobel Prizes in medicine and physiology than the entire rest of the world combined. We won three more two weeks ago. Only one of those Nobel Prize winners was actually born in the U.S. The other two made the decision to come here because it was so favorable to medical research. This medical research isn't just benefiting us. It is

benefiting the entire world. It's like our most important humanitarian foreign aid, like a medical marshal plan for an aging globe and we want to make sure no matter what decisions are made in Congress, they do not imperil that most wonderful product of ours. I want to thank you all for coming.

-End of Discussion-