THE DILEMMA OF UNCERTAINTY (copy of a lecture by Aron B. Bick, MD)

My friend, Dr. Yzhar Charuzi, has provided me with this forum to shed the light on my personal experience and views of the Medical World that has been an active part of my life for close to forty years. Although I certainly do not feel old, it is undeniably true that many years have passed since I entered the world of pre-med, left for France to pursue medical school, returned to the Medical Mecca's of the United States to pursue training in residencies and fellowships, getting my feet drenched in the world of private practice and ultimately being now in the position of seeing the approach of my status as Emeritus Attending. I would like to thank all of you for the opportunity to reflect and to attempt an exploration of the medical world we live in, and I would like to make the disclaimer that the opinions I am expressing here are strictly my own.

As physicians, we are faced daily with seeming uncertainties of our patients' lives, as well as our own lives, and without even being conscious of it; we handle all those unknowns quite well. Today, we are faced with political and economic challenges that may seriously impact on our way of delivering healthcare, on our patients' well-being, on our autonomy as physicians, and of course on our pocketbooks. The assumption that life would continue for us in the historical model of medical practice is being constantly shaken.

Even before I first started my own path in the medical world, I truly was a socialist at heart and was moved by the story of "a country doctor" (Penguin Books). I saw myself as simply healing the sick. It's amazing how far off I was from the real career target that was to come. When I started, I had no clue that I would become, in addition to a physician, a businessman, an administrator, and a politician. If at first I was uncomfortable with money and healthcare, I gradually overcame that dilemma. There's an old joke from my background that states that if you were never a communist before age twenty five, it indicates you were never a youth; but if you are still a communist after age twenty five, it means you never grew up.

As residents, you are somewhere in the middle phase of your journey. As such, you have built some self-confidence about our profession, but are still very apprehensive about the future. In today's constantly shifting medical world, the uncertainties and anxieties just keep adding up, to the point where all physicians are confused and apprehensive about the future. Our uncertainties include the financial and professional aspects of our careers. Thus far, you proved that you are able to solve problems: how to survive pre-med, how to get into med school, how to land a residency at the prestigious Cedars Sinai Medical Center. What is still not clear is what happens after residency, what sort of career you will have and how much money you'll make, which in turn will determine your lifestyle. You are transforming from the judgmental youth where every private practitioner is a sell out, to a maturing adult who realizes that money is important and has its place and role. You now are learning to appreciate that becoming a Doctor is less about luck and more about hard work. It is starting to dawn on you that this goal you've been seeking for so long means that you're committed to eternal hard work and
lots of personal sacrifices. And yet, you already know that the rewards are well worth it. You have entered a life in which you are surrounded by lots of people yet you find yourself often alone in the battles against diseases and the unremitting demands of your patients, your peers and institutions. You will be spending days and nights pursuing the answers and tools that will help you in these battles and you will likely sacrifice many potential relationships and encounters with family and friends. You have grown up in a competitive dog eat dog environment and you are the winners of those endless contests. How ironic it is to have worked so hard towards the goal of helping our fellow men and women only to find ourselves trying to out-compete our fellow humans in the selective hurdles for medical school, Residency, Fellowship and private practice patients. Some of you may think you may be able to avoid the rat race of private practice by going into academics or by escaping into a salaried position (such as the Hospitalist program here at Cedars or perhaps a Kaiser model). I am here to reassure you that the competitive world permeates our entire profession! And how can it be otherwise? The process selects the most talented and most ambitious of society.

RAILROADING

And still, we really are members of the most noble profession. As physicians, I believe, we are the most ethical, hardworking, committed, reliable and conscientious members of society. Our world is being aggressed by money focused, manipulating, scheming and unscrupulous individuals and entities. We, as physicians, have to actually face the patient and we are the patients' last line of defense against an ever changing hostile healthcare delivery system. We should never feel guilty about making a great living off of our profession. We should never be railroaded by the MBA's, lawyers and politicians who berate and degrade us by pointing fingers at us claiming fraud, unethical behavior, malpractice, etc. We should be aware of the agents of the mega-corporations who are dressed as supervisors, chairmen of departments and so forth, but who at the end of the day are simply part of the control process which entices us to work for reduced fees or even for free. They propagandize us with false pretenses, false prophecies, and non-experiential advise. They are creating paradigms for us when, in many cases, they know not what they do. Perhaps we should consider keeping all non-physicians out of the world of medicine except for roles that have no direct bearing on physicians and patients. They all should be working for us, and not vice-versa. We will always be working for the benefit of our patients whereas their fiduciary role is always on behalf of the corporate entities and their own survival.

FORTUNE TELLING

The politicians and administrators resort to tools of control which involve fear and false prophecies. The sad part is that many of us buy into this rhetoric. I recall my first day of internship in 1981 in Brooklyn, when a private attending at morning rounds claimed: "you poor souls, by the time you guys will finish your residency, private practice will be history". In retrospect, that prediction turned out to be my first lesson in the popular art
of Misguided Fortune Telling. Over the years I have encountered many forms of false predictions, including "cancer has no cure", "HMO's will be your only option", "and the days of the megabucks in medicine are over", etc. It got to the point where even some of my colleagues are trying their own fortune telling skills on their patients by making inexplicable comments such as "you have three months to live". Then, there are the Fortune Teller wannabe's who will try to point out half-truths such as "doctors are lousy businessmen" or "corporate medicine is going to take over the world" or "Cedars Sinai will get rid of all private practitioners". Unfortunately for me I have never been offered a course in fortune telling, and as far as I can judge, my colleagues have never perfected their predictive abilities either. Thus, I propose that we all remain humble by accepting that there are inexplicable forces beyond our own microcosms. We need to maintain calm and follow common sense. We must abide by the scientist in us and stick to the certainties of what we do know.

THE KNOWN

What we do know for certain is that we, as physicians, have developed, over years of hard work and dedication, skills talents and views that few other members of our society possess. We know that we have survived a selective process that chooses humanitarian, intellectual, work ethic and multi-tasking attributes. We can pretty much tackle and succeed in any new adventure, including even CS-Link! We can be awakened at any time of the night and be focused instantly and correctly about life or death decisions. We have learned to deal with daily human tragedies and exhilarations, and yet go home to our families and friends and integrate seamlessly as "normal" human beings into the banality of everyday life. We have learned to be politically correct and politically astute. We have even learned to take a certain amount of emotional abuse while mastering the art of remaining "professional". (We even learned not to yell at other healthcare delivery personnel even if they disturb our sleep in the middle of the night for issues that can certainly wait until morning). In fact, we are constantly defining the true meaning of "professional" as throughout this entire process of caring - truly caring for the sick - we keep maintaining our humanity, demeanor, educational pursuits, our people skills, and even lots of smiles.

I love being a physician because it allows me to be not only a mere technician, but a thinker, a mover, a shaker, a decision maker, a pathfinder, a detective, an educator, a soother, and most important, it allows me to transcend the entire spectrum of the Human Condition. It integrates me fully into society's social structure while impacting strongly on individual lives. In my own practice, I care for a vast array of humanity, including people of various colors, shapes, languages, cultures, genders, sexual orientations, professions, economic strata and the different varieties of psychotic or neurotic upbringings. I am challenged every day to become the perfect physician for the individual patient sitting before me. Although I will humbly admit that I am not always successful, I can unabashedly declare that for the most part I certainly make an impact.
I welcome all of you into this world of caring, giving of one's self, dedication, empathy and challenges.

TODAY'S HURDLES

Today, our society is facing seemingly insurmountable hurdles in our quest for a better healthcare delivery system. We are in constant fear that the life we signed up for will be taken away from us. FDR told us that "The only thing we need fear is fear itself". The Talmud teaches us that "the whole world is a narrow bridge, and the essential is not to be afraid at all". Fear is just another word for "The Unknown". (I guess that's why we try to engage in fortune telling, so as to have at least the illusion of knowing what's to come). I suggest that instead of focusing on the unknown, we engage in facts and in what IS known. So here are the known facts: The human machine breaks down with time and we are all doomed to die. The Good Lord cursed Adam in the Garden of Eden with a death sentence because the First Man had the audacity to be curious and taste the fruit from the tree of knowledge. It seems to me that God then had remorse and decided to create physicians so that man, although still doomed to die, will at least not suffer in pain and illness. Yet certitude is that there will always be physicians, and there will always be patients. Still another undeniable fact is that no labor goes unrewarded, and thus our salaries are not in peril. ObamaCare is the least of our worries, and in fact, it may turn out to be good for "our side". Economic theory is based on supply and demand, such that if President Obama wants to throw thirty million additional patients into the mix, how bad could that be. Note that even if the politicians realize their own folly and miscalculations and decide to train more physicians, one will need at least ten years to see the first bunch of young physicians roll off the assembly lines. Add to the equation an aging population, innovative treatments (ah, the beauty of academia - each journal publication results in spending more healthcare dollars on patients), popular clamor for "give me the best care", the changing demographics and priorities of healthcare professionals, and you have job security for generations to come. The only scenario that would contradict these facts would be the possibility there would be no more patients. On that theoretical musing, there are only two ways we could achieve that goal: 1) we'll have the cure for all diseases (and by implication, we would have found immortality) or 2) we do the most cost effective maneuver and let all diseases take their natural course without monetary expenditures! By looking at historical facts and at common sense, I can safely state that neither one of those options will be exercised within the next several generations. Therefore, calm down as there will be plenty of work for all of you! More than you'll be able to handle.

THE ALPHABET SOUP
So if we need not fear unemployment, and we need not fear losing patients, why are we all still so apprehensive? The answer is, of course, "the unknown". Who will run the show called Medicine? The real fight out there is precisely about this control. Politicians, bureaucrats, and lots of people with all sorts of unresolved childhood issues are trying to confuse and control us and our hard earned talents and labor. So, they use the old true and tried methods of divide and conquer, playing up our individual insecurities, trying to confuse us by throwing a whole new alphabet soup our way, such as HMO, IPA, PPO, ACO, LSO and thousands more incomprehensible and irrelevant acronyms. Every few years they try a new tactic by essentially forcing key physician-administrators to try and propagandize and demoralize us with the alleged merits of various new regulations and hurdles. Most of you were too young when only eighteen years ago President Clinton and his wife threw our way the concepts of the "Health Mandates" and our own hospital was fully committed to implement these then "new" concepts, only to find it was a total waste of time and money. Under the guise of such statements as "it's mandated by JACOH" or it's for "patient safety" and a whole slew of double-speak we end up trying to teach and herd young physicians into concepts such as "cost effectiveness" and "evidence based medicine" and many other half truths. While in the Ying Yang of life, cost effectiveness may need to be considered, what a horrible conflict of interest this becomes for the physician in the trenches. The unspoken truth is that the most "cost effective" management for a ninety year old patient with multi organ failure is to let him or her die in the ER (or better still, at home). And yet, not only may this turn out to be immoral and a huge conflict for both physicians and for the LOS conscious hospital, but it may even end up detrimental to the economic interests of the healthcare industrial complex. Is our society truly in favor of allocating more resources to bombing the Taliban half a world away then to the tax payer right here at home who contributed a lifetime of Medicare dues (and where those contributions were used up for unrelated projects)? Do we really want to place the burden of such decisions upon the shoulders of young physicians who have scant training in global economics? Is our role to be mere technicians who will work robot like in implementing the ever changing and whimsical social experiments of our not so great leaders? I propose that we all strive to work under the banner of "we want to treat our patients the way we would want to be treated if God forbid we were ill"! What a concept!?

Thankfully, we need not worry, as history, facts and common sense almost always prevail. Historically, HMO's are still a minority of the health care system. Fact is there is a lot of resistance to it from the patients' side. Common sense would dictate that if folks are not stupid, then perhaps they are choosing correctly. This lecture is not meant to address my opinion on the future of Health Care in the US, rather, I would like to address you, the young physicians and the possible fear you may have acquired in this world of turmoil.

OPTIONS
So, let us address the near future for those who are graduating your training in the next year or two. You still have the same career choices that I had when I graduated my training twenty five years ago. Your path will be the sum total of your individual self. You can still chose academics, research, Pharma, Corporate or Organizational Practice, or private practice in a group or as a solo practitioner. You can choose whatever geographical setting you desire. You can be a country doctor, or a telemedicine surgeon, You can become a physician businessperson or a physician-administrator. You can become a philosopher, writer, film maker, or an educator. You can work part time or full time. You can be a hospitalist or a Peace Corp adventurer in the Albert Schweitzer spirit. Each path has different economic and lifestyle advantages or disadvantages, but you always have options, and you always can change your mind and your directions in the future. The one common denominator is that you will always be a physician, with a special eye and heart to the patients and their needs. You will always be the patient advocate - because such is our nature. You have been selected by life itself to walk this path. Feel free to unburden yourself from the control of others whose main goal is to amass their own individual wealth and/or notoriety at the expense of the well-being of others.

**ECONOMIC MEDICINE**

I'd like to turn the subject now towards good medicine as it relates to good healthcare economics. The dirty word of the "occupy" movement, Globalization, is actually a beautifully functional word in our world of Medicine. To globalize individual care means we should look at the entire, or global picture of the patient's life path. To globalize the healthcare dollar, means we should look at the global options and expenditures and allocate funds in the most effective, efficient and patient directed manner. We should also address the global goal of what it is we want to achieve. The problem, I feel, with our current way of practicing medicine, is that we are lacking precisely that global vision. An example came our way a few months ago in an op-ed article in the LA Times when the head of a large hospital wrote that the main reasons for the government to help hospitals survive is because these institutions create jobs. While jobs are certainly important, I always felt that the main role of a hospital is to provide a welcoming (from the root word - hospitable) place of healing. The emphasis should be focused on the fact that we're here mainly to care for patients rather than to create jobs! The historical irony is that hospitals were originally established as charitable organizations in the middle ages to house - often for years - the very sick and the undesirables of society, yet today's evolved hospital model places the emphasis on getting the patients out within the statistical LOS. If the goal is to ALSO create employment, then we as physicians are the movers and decision makers in regards to such jobs. We the physicians ultimately decide which patient gets worked up and how, and we decide on the treatment paradigms. The rest is just buildings and personnel. Please note that less
than thirty years ago it was illegal to write a DNR order in a patient's chart. Some dedicated physicians and nurses became politically vocal about this issue, and helped transform society's resistance to the pursuit of futile care. Yes, physicians definitely can and should direct medical care not only at the individual level, but also in the institutional and societal arenas as well!

In fact, I can argue that up to eighty percent of all hospitalizations can and should be avoided. Patients can and should be evaluated in physicians' offices, urgent care centers, ER's; and treatments should be rendered as much as possible in surgicenters, infusion centers, physicians' offices, dialysis centers, cancer centers, etc. Our current paradigm calls for hospitalizations for prolonged periods of time, mainly for convenience's sake (for doctors and patients) and with disregard for costs. I will submit that the main reason to hospitalize patients should be for ICU care, peri-operative care, trauma, cardiac monitoring, and social reasons. Even these categories are slowly dissipating as we have new surgical technologies that allow the elimination of inpatient necessity (e.g. MRI directed US ablation of brain lesions which would avoid neurosurgical intervention altogether). Also, outpatient resources such as mobile care, home health and skilled nursing and supervised living are becoming universally available. Infusions and hemodialysis have been outpatient procedures for years. Cardiac workups, are already routinely performed in an outpatient setting. When you check the AMA statistics regarding the healthcare dollar, you'll find that ten percent of that dollar goes to the healthcare provider, while the rest goes to Pharmaceuticals, Laboratories, imaging, hospitals, administration and insurance companies. I would propose that we raise the physicians' percentage to twenty percent, incentivize them to do more on an outpatient basis and keep patient flow as outpatient. The individual patient (and please let us insist that we should address them as patients, not as "clients") should also be addressed globally. Upon presentation to the ER, most services should be provided right there: evaluation, treatment, and disposition to, where feasible, to an outpatient care center. The Sickle Cell patient who lingers for weeks in the hospital, the community acquired pneumonia patient who stays for a week or more, the seizure patient who is admitted for 3-4 days for a workup etc. etc. The nursing home patient who is admitted repeatedly through the ER whereby the underlying truth is rarely addressed. All these can and should be managed outpatient. True, social and medico-legal issues abound, however, with the proper set up, education and political will, these are not insurmountable. If we are truly intent on saving money, we should incentivize and empower the physician-manager to do more and better on the outpatient side. The medico-legal fears need to be allayed. The societal (false) beliefs need to be addressed and changed. The financial incentives must be realigned. Academic, legal and political expenditures should be separated from the mainstream medical budgets.

Jobs will not be eliminated, on the contrary. Jobs will be shifted to an outpatient model and probably increased. Patients will be closer and better monitored as there will be better continuity of care and the mixed messages from unwitting house-staff and full
time attendings will be avoided. The doctor-patient relationship will be strengthened such that issues like end-of-life care can be discussed with greater ease and understanding, and not upon entry to the ER where emotions and stress hinder clear thinking. As young physicians, you are on the verge of new paradigms and you have a choice of engaging in this future or joining a historical model whereby you'll simply do more of the same.

Perhaps you feel this scenario is too Utopic, however, upon deeper reflection you'll probably agree that this paradigm can be implemented, tweaked as needed and ultimately embraced by all parties. Let us run through some examples that will demonstrate my point. Again, I would like you to reflect on the first portion of this talk where I have expanded on the point that we, as physicians, are a very ethical, hard working, dedicated, honest, and innovative segment of society. As such, it will be up to us and us alone to implement the upcoming changes in healthcare.

THINKING GLOBAL

A different angle at cost savings is the up-front global decision making. Aggressiveness of care, shortest workup to diagnosis, eliminating certain procedures, and getting consultants reflexively, are but a few of the techniques. As internists, you should refer to specialists only for procedures and specialized opinions. You can and should do most of the workup and even treatment, yourselves. An example, and there are tons, is a 75 year old male patient with an elevated PSA. Such a patient can and should be managed for a fraction of the cost of what is "standard" practice, and without ever involving an urologist. I'd get Total PSA, free PSA, outpatient prostate US and Bx via a radiologist, metastatic w/u outpatient, if no mets then referral to radiation therapy, and if he has metastasis, then Cassodex and Lupron can be given even by an internist. With low Gleason scores and the elderly patients, one should even consider no treatment at all, but simply controlled and conservative management. Why not allow even the elderly enjoy their remaining sex lives and their urinary continence. Why even bother referring such a patient to an urologist whose mind set, belief structure and financial incentive is to perform invasive procedures. Now let's look at the flip side: the patient goes for a procedure, potential complications, hospitalization, quality of life and you have a major financial expenditure, not to mention the human cost. The decision we make up front, has repercussions all across the health care and human spectrum. To the saying of "do no harm" you may want to think about "make no waste". The reason a patient IS referred to an urologist, in the case of an elevated PSA is fear (medico-legal) patient insistence, complacency, or time management constraints by the internist. I say to all of you: buckle down, learn, apply and make more money for yourselves while saving even more for the country.

There's nothing in our education that states every patient must be intubated before they pass on. Nothing that requires a cystoscopy in every person who possesses a bladder.
Nothing that warrens fourth line chemotherapy in an end stage lung cancer sufferer. Nothing that forces an ER physician to admit the asymptomatic and yet undiagnosed CML patient with a 100 thousand white count (and at 10 PM yet). Think conservative and leave the aggressive care for those who will truly benefit from that sort of approach. You as the physician are always the decision maker regarding what is appropriate for your patient. The decision to intubate a hopelessly end stage patient is an active decision on your part. Reflect hard on what are your goals, the patient's and family's goals, and what are the realistic expectations in the particular case. You don't have to act reflexively, nor against your beliefs.

If we have time and audience interest, I can go through many examples in my specialty where money is wasted, patients are made to suffer or be inconvenienced needlessly, and the internist loses potential income and control. I can bring you examples from practically every specialty and subspecialty. Yes, we do have to deal with patients' lack of trust or misinformation, as well as their "meshigas", but is it not part of our role to educate? Unfortunately, the incentives are wrong and it is much easier today and cost effective for the physician today, to send the headache generating patient to a specialist, who in turn serves as our Tylenol. Or better yet, we end up intubating some poor soul against our better judgment because that act will provide us the medico-legal Tylenol.

GOING OUTPATIENT

One of the politically wrong paradigms in today's training of young physicians, is that this education continues to be hospital and inpatient based. We are on the verge of a major revolution in healthcare, whereby care is shifting to the outpatient arena. And yet, the training continues to be mostly inpatient based. My proposals are not on the forefront of the political vision of the healthcare think tank. But yet, only two or three decades ago partial gastrectomies were a significant portion of a general surgeon's repertoire. Then along came Cimetadine and today you will hardly find a patient hospitalized for such a procedure. During my Fellowship, practically all chemotherapy was administered inpatient, whereas today it is a rare occurrence. True, the introduction of Zofran changed the landscape, but it was also social and medico-legal acceptance. On the opposite side, our hospital had correctly foreseen the trend, and correctly invested in an ICU tower (Saperstein). Our administration correctly foresaw that much of what has been inpatient medicine will be moving to the outpatient setting, and hospitals will be needed mainly to treat the very ill. Still, if we do our job as physicians, many ICU candidates can avoid that particular experience by preventive and prophylactic engagement of the patient and appropriate selection of the candidates who enter that tower. The trend is evidenced by the fact that at least three hospitals within a
two mile radius of Cedars-Sinai closed their doors within the last 15 years, and the two remaining hospitals other than Cedars cannot fill their beds. Somehow, patients have not been abandoned, Physicians are as busy as ever, and more healthcare jobs have been created.

If we look at the global scene, then we should further cut costs and eliminate the bizarre parallel healthcare deliveries of the VA, and Workman's Comp. We should also be vocal about the non-healthcare inclusion of the Medico-legal and personal injury expenses in the so called healthcare dollar. Finally, we should also address the "entertainment" and "religious" aspects of that dollar, since a significant number of patients see their physicians because of loneliness, psychological issues, and belief structures. These last issues should really be addressed by social workers, psychologists, support groups and clergy.

HMO's

Now I'd like to say a few words on the HMO system that the government and insurance companies are so eager to embrace. Some hospitals, such as our own, are also jumping into the frenzy, though for somewhat different reasons. HMO is capitated care. That translates to "you give me a set dollar amount, and my business side encourages me to spend as little as possible of that dollar, because each dollar spent cuts into my profits". The cynic in me feels it is more like Health Mismanagement Organization, or Decapitated Care. The insurance Company and the government are essentially shrinking off their role as risk takers in the insurance game, and are placing the burden and risk on the shoulders of physicians. If you are like me, you have no education nor experience in actuarial management, you have no financial backup, and no control as to who walks through your door. You become an unwitting sucker in this huge financial manipulation whereby you have to explain to the patient why his workup or care are not being approved because whatever you put down in your note does not meet guidelines. The institution (hospital, IPA, Kaiser, or whatever) is one degree removed from the patient, and the insurance company is totally removed ("sorry, that's the system"). Since in a capitated system the premiums are paid up front, the insurer who in theory is meant to take the financial risk takes its cut from the top and shifts the risk downstream. The IPA takes its cut from the next payout, and you as the "provider" are facing the onslaught of needy, handicapped, unsophisticated and clueless patients, all the while having to hire additional personnel to address the added paperwork. Remember, you have been educated, trained, and licensed by the State to properly perform your art. And yet, a bureaucrat disguised as a Utilization Review person will deny your request for an imaging study because your clinical judgment and decision do not meet "criteria". That decision to deny your patient the study is made by a person who has never seen, examined or talked to the patient. Frankly, what gives is morale, income and quality patient care. But, you claim, we have no choice! False,false and false! Fear not and address that "train that left the station". My relatives were forcibly and literally
placed on the non-proverbial version of such a train and ended up in Auschwitz. This story is more about railroads rather than trains. Dear colleagues, we are being railroaded! The only way one can be controlled is through fear and I can only underscore that we have nothing to fear. By taking control of the healthcare Dollar, physicians can only shine and patients can only benefit! The current political landscape is strictly about money and control. Under the guise of "better patient care" your pocketbook, time and autonomy are being aggressed. Even the politicians and pundits admit that the HMO care is inferior, for "you can't expect to get a Cadillac for a Chevrolet price". However, if you stop and think for a minute, you'd realize that the Healthcare Dollar is not given to the patient. Instead, it is given to us, the providers. So, if the Healthcare Dollar is smaller, and you stuff the system with middle-persons and bureaucrats, the net Dollar to the provider has to be reduced even further. The physicians are then left with the dilemma of having to provide less expensive and inferior care.

PRIVATE PRACTICE

So, you ask, how can one still succeed in private practice? The answer is "the old fashioned way". Realize that there is always room in every business for one more player. In medicine there's definitely room for more physicians. By limiting the number of medical school candidates, the AMA has insured a shortage of physicians for generations to come. on a side note, a soon to be published article in the New England Journal of Medicine argues that we do not need more doctors. I suspect the propaganda machine is being oiled before our very eyes, much to our benefit. Find a niche that's unique to your own individual self. Be innovative. Think outside the box. Follow the rule of "not only but": not only should you strive to have the strongest knowledge base, but be a better clinician, a better people person, a better listener, a better communicator, have better bedside manners, be more approachable, more accessible, more connected, more networking, more multi-locational, multi-cultural and so on. Learn more from those experienced and less from the academicians and full time attendings who are not only poorly versed in private practice but feel compelled to give lots of misleading advise out of their own insecure and fearful worlds. Learn basic business skills and do not buy into the fear mongers' mantra that business is too complex for physicians to master. Most importantly, fight aggressively against your own desperation zone of "I cannot possibly do it". In a changing environment, take the high road and the global view.

UNCERTAINTIES

Finally, let us address the title of my talk: how to deal with the dilemma of seeming uncertainty? You are and will always be at the apex of the Healthcare pyramid. You
have talents and skills that few possess. Take the bull by the horns and become the true face of the healthcare system. Remain calm, suppress your fears, stay true to what you already know to be factual and avoid fortune telling. You do have many options and you do deserve to make a respectable living off your labor. You have fought hard to obtain autonomy and you should never lose yourself respect. This world is rapidly changing, so take advantage of the new opportunities. Think outside the proverbial box. Uncertainty is by definition uncertain, so what?! When I see a newly diagnosed cancer patient, I start with the uncertainties of diagnosis, stage, therapy, side effects, and prognosis and so on. The patient has the uncertainty of health, life and the ability to pursue happiness. Slowly, calmly and rationally we all work things out. Financially, we the physicians are now facing uncertainties in the healthcare delivery system. Slowly, calmly and rationally we will overcome. The current "fear du jour" is we'll all lose our Medi-Medi patients to the HMO's (Even the Foundation here at Cedars-Sinai has begun its fear mongering by suggesting to physicians that if they don't sign up now they will miss out on "the opportunity"). As of today, absolutely no one can make such a prediction with certainty. There are still many questions about what exactly will be done and how the program will be implemented, if at all. The political battle lines are only now being drawn. Based on the three prior attempts during my own career, I will guess that this latest attempt is not a real threat either. When bureaucrats tell me "you have no choice" they are speaking either out of ignorance or perhaps out of their subconscious wickedness. Of course we have choices! We certainly have more options in life than most anyone else in the world. There IS no train and even if there was, it is not due to leave the station until at least June of 2013. In between, we still have to hear from the Supreme Court about ObamaCare and we have elections to go through in November. Always stay focused on your original goal of making this world a better place! That is our true challenge and dilemma. Our patients depend on us with their lives. You have achieved a lot and you're just getting started. You can indeed do it and that, my dear colleagues, is definitely NOT an uncertainty.

Thank you for your time.

Aron B. Bick, MD