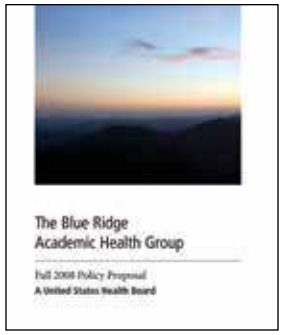
Letters to the Editor

All things considered



I always enjoy reading *The Pharos* and was particularly interested in the recent editorial by Dr. Byyny on "All things considered…The future of the U.S. health care 'system,'" which nicely outlines the problems with health care delivery in the United States with a logical and practical solution to create a National Health Reserve System.

The Blue Ridge Academic Health Group (BRAHG) http://whsc.emory.edu/blueridge/index.html, was founded more than 20 years ago to identify ways to improve our health care delivery system, with special focus on the role of academic health centers. The BRAHG consists of 15-20 current and former academic health centers leaders who meet annually for three days with national thought leaders to study and report on a topic of timely interest.

During BRAHG's discussions of health care reform in 2008 we developed a "U.S. Health Board" modeled after the Federal Reserve System, which we proposed to those responsible for drafting the Affordable Care Act (ACA). This effort was led by Steve Lipstein, who was then President and CEO of BJC HealthCare, as well as a member and subsequent chair of the St. Louis Federal Reserve Bank. The report (http://whsc.emory.edu/blueridge/publications/archive/blue_ridge_policy_proposal_final.pdf) was distributed widely and discussed with senior members of Congress and health care organizations, but it never received serious consideration in the highly charged political debate over the ACA.

The concept of a National Health Reserve System was promoted more than 10 years ago by academic health center leaders, even before the implementation of the Affordable Care Act and well before the most recent health care delivery crisis precipitated by the COVID-19 pandemic. Hopefully this time it will receive more serious consideration. As well said by Winston Churchill, "Never let a good crisis go to waste."

Fred Sanfilippo, MD, PhD
AΩA, Duke University School of Medicine, 1987,
Alumnus
Atlanta, GA

I very much enjoyed reading Dr. Byyny's outstanding article on reformation of the United States health care system (Summer 2020 pp.2–10). One of my best friends, Dr. Robert Burnett, now deceased, was very active in organized medicine proposals for health care delivery. He, with associate pediatrician Glen Austin, published, "An Innovative Proposal for Healthcare Financing," in *Pediatrics,* Vol 3 May 2003, proposing the Federal Reserve model. While this paper did not appear among your list of references, their paper was very supportive of your proposal.

Donald J. Prolo, MD
AΩA, Stanford University School of Medicine, 1960
Saratoga, CA

The editorial in the summer issue was a very good commentary on the current state of the United States health care system. Dr. Byyny stated, "One of the most important outcomes of the COVID-19 pandemic is that it has exposed that the U.S. does not truly have a 'health care system.'" That fact has been evident for the past century! Teddy Roosevelt, Harry Truman, Lyndon Johnson, Ted Kennedy, and Barack Obama all recognized this and in their various ways addressed it.

With 50 million-60 million Americans without health insurance in 2009, President Obama was able to start work on, and eventually pass, the Affordable Care Act (Obamacare). This monumental health care reform only insured 20 million, left millions underinsured, and did little to contain costs. What COVID-19 did was to exacerbate our dysfunctional health care system as individuals lost their jobs and with that their employer-sponsored health insurance!

Dr. Byyny's solution revolves around the creation of a National Health Reserve System analogous to the Federal Reserve System for monetary policy. Senator Tom Daschle in his 2008 book, *Critical—What We Can Do About the Health-Care Crisis,* postulated a similar solution which he called the Federal Health Board described as a quasi-governmental organization with a board of governors appointed by the President and confirmed by the Senate. In addition, there would be regional boards similar to the district boards described by Dr. Byyny. This structure could be useful in overcoming the Federalism approach to health planning and public health coordination which COVID-19 really exposed as inadequate, deficient, and disastrous! In addition, it could perform functions similar

to the National Institute for Health and Care Excellance in England by evaluating new and existing pharmaceuticals, medical devices, and procedures for their efficacy, safety, and cost effectiveness.

The most important solution in solving our dysfunctional health care system is the comprehensive creation of a rational payment system that eliminates the waste, fraud, and unnecessary care of our multi-payer system! Such a system as proposed by Physicians for a National Health Program exists and is detailed on their website.

With this system of "socialized payment" and private provision of health services overseen by some form of National Health Reserve System as Dr. Byyny proposes all aspects of universal health system can be realized!

Nick Anton, MD, FACP
AΩA, University of Iowa Roy J. and Lucille A. Carver College of Medicine, 1970
Santa Rosa, CA

The landscape of academic medicine and health care in the United States

The article and accompanying introduction in the Spring issue of *The Pharos* (pp. 2-8) identify the many challenges that confront academic medical centers (AMCs). However, the list is incomplete. This is a moment when the very purpose of the AMC must be re-examined.

In the century since Flexner, the underlying assumption has been that a firm grounding in biomedical science must underpin clinical practice, not only medical education and research. More recently, the social sciences have been added, since they complement the purely biological perspective. No more dramatic evidence of the interdependence of biological and social factors need be sought beyond the current COVID-19 pandemic, where economic and political factors are influencing entire continents' responses, over and above knowledge of the virus's biology.

Arguably, Flexner would probably have embraced the inclusion of non-biological factors in the scope of medicine, but not as a substitute for rigorous consideration of the interplay between biological and non-biological influences. In some ways, this is a microcosm of many of the questions identified in the article: what are the AMC's responsibilities, above and beyond narrow considerations of disease?

Undoubtedly, the AMC is certainly challenged. It is important to realize that many of the organizations cited in Collins's *Good to Great* have faltered badly in the years since the book was written. To put this another way, what made those companies great was insufficient to sustain them. Athletes and management consultants call this phenomenon "The Fade," which is the rule rather than the exception for organizations and individuals alike. The common element is that the environment in which they operate changes more than is appreciated. It is not so much that the external flux is rapid, but that it calls for more dramatic change than many organizations are equipped to recognize, embrace, or undertake.

Today, the AMC is caught in a iron triangle of competing forces and expectations that are not easily reconciled and are, perhaps, even irreconcilable. Is the AMC to serve individual patients, or as a public health resource? Is its primary mission education and research (i.e., scholarship), or is it clinical service? Are financial considerations and the need for growth ends in themselves or secondary?

Many of the dilemmas cited in the article have come to the forefront because it is no longer possible for the AMC to avoid addressing such trade-offs directly. This is not easy for any organization to do, but particularly not one that is steeped in academic traditions and deliberative procedure. This is one of the major sources of tension between hospitals, which may interpret community expectations for service and economics differently than their universities or affiliates.

In that regard, on a personal biographical note, in the 1990s, I was the chief physician of The Johns Hopkins Hospital, later becoming one of the early architects of the Partners (Massachusetts General-Brigham) System in Boston, and then a partner in an international strategy consulting firm. At the turn of the millennium, I gave a talk to a group of deans and hospital chief executive officers about the issues that might be on their agenda for the decade to come. I stressed two things: that the economics of the AMC were unsustainable, and that basic questions of mission needed to be re-examined. The talk was not well received. The major objection: we have balanced effectively conflicting expectations for a century, why is this era likely to be any different? The answer: the external environment is less forgiving in all respects, those biological, social, and economic.

What are the implications for today? No easy answers, here. Your article identified many of the questions to which attention must be given. These are, however, primarily directed internally. Inescapably, if the AMC is going to survive in anything close to its historical form, at least three questions concerning its external role must be addressed in advance of any examination internally. What are the AMC's responsibilities to its local community? How

far should its programs reach, regionally, nationally, or beyond? What boundaries to the scope of its involvement are desirable, given that not every AMC can be equally strong in education, research, and clinical care?

Unless these questions are addressed first, it will be impossible to know how to tackle capital allocation; investment in, or curtailment of, programs; how to effectively engage the faculty and leadership; or any of the other many challenges that can only be partially anticipated at the outset.

In short, it is unlikely that any AMC can navigate successfully these unforgiving times unless it makes explicit those beliefs that have long been implicit.

Johns Hopkins, the Quaker merchant founder, anticipated the need for periodic re-examinations of purpose and mission. In his original bequests, Hopkins identified his reason for the University: "...because new knowledge will always be necessary...." And for the hospital, "...because there will always be human suffering ...." He saw the two as being closely related, but distinct. Those beliefs are still sound today, more than ever.

Hamilton Moses, III, MD
AΩA, Rush Medical College of Rush University, 1975
North Garden, VA

Burnout

Kudos to AΩA for a focus on physician burnout (Burnout and resilience in our profession, Winter 2020, pp. 2-6). The best strategy for dealing with the topic was shared with us in the article by Ms. Mark's father, i.e., once you see yourself as a victim you become immobilized, weakened, feel powerless and are unable to effect change.

In my 60 years of practice I saw so many inspirational examples of the resilience of the human spirit that I would often come home at night truly humbled. I hope and suspect that most physicians have had similar experiences. Some patients I recall include the Black woman living in a disadvantaged community in Chicago, working and raising her children where gunshots are nightly background music. The undocumented immigrant working two jobs with two illnesses—diabetes and hypertension—no health insurance who comes to our resident's free clinic because he has no other option for care or medication. These could be considered victims, but do not see themselves as such as they persevere, often finding joy in their daily lives. Our profession should be so resilient.

Physicians of all the groups in the United States today are not victims! This not to take a PanGlossian[1] view of the state of medicine in 2020, quite the contrary. I understand the problems of the electronic health record (EHR), especially for us older practitioners with limited typing skills; the issues of corporate practice that conflict with our ethical commitments to our patients; and the nonsensical government and insurance regulations that drive us nuts on a regular basis. These are indeed real problems, but with solutions of which we should be an integral part.

When we come to believe that there are no remedies we are toast. If your work environment is so stifling that you are becoming burned out, change it! If the EHR is the culprit, get a new system or delegate the parts that are not directly relevant to care to someone in the back office. If the "business of medicine" where you are practicing is so repressive and at odds with your values, quit and find a new organization. There are many that still consider patients before profits.

If you assume the mantel of the victim, slogging to and from work each day, simply complaining loudly in the doctor's lounge, or dining room, or at home, my sympathy is limited to those who have to listen and put up with you. Come on colleagues, suck it up, we can do so much better for ourselves and especially for our patients many of whom truly are victims of their disease, their total burden of illness, and their poverty.

References

1. Voltaire (FMA). Candide, ou L' optimism. 1759. Cramer M-M Rey Paris, France.

Jim Webster MD, MS, MACP
AΩA, Northwestern 1983, Faculty
Santa Fe, NM

George Engel and the origin of the biopsychosocial model

The article, "George Engel and the origin of the biopsychosocial model" by David H. Rosen (Winter, 2020, pp 18-20), purports to describe the influence of Dr. Engel on American medicine and the development of his interest in the mind-body relationship at Harvard, and then at the University of Rochester. Although Dr. Rosen was on the faculty of the Department of Psychiatry at the University of Rochester, and colleague of Dr. Engel, he left out some key elements of the history of the biopsychosocial model.

Dr. Rosen's article does not provide an accurate picture of the development of this important movement in American medicine. Most are covered in three publications.

- Sharon R. Kaufman, *The Healer's Tale, Transforming Medicine and Culture,* Wisconsin, 1993,
- Jules Cohen (AΩA, Weill Cornell Medical College, 2001) and Stephanie Brown Clark (AΩA, University of Rochester School of Medicine and Dentistry, 2006, Faculty), *John Romano and George Engel, Their Lives and Work*, Rochester, 2010; and
- Diane S. Morse, Katherine R. Johnson, and Jules Cohen, *The Evolution and Legacy of the Engel and Romano Work in Biopsychosocial Medicine*, Rochester 2013.

My father, Dr. John Romano (AΩA, University of Rochester School of Medicine and Dentistry, 1948), was a leading figure in this field in the Department of Psychiatry at Cincinnati, and later at Rochester. He invited Dr. Engel to join him at both of these institutions and to help him create the model of teaching and patient care that is now known by some as the biopsychosocial model. It was Dr. Romano who worked to create the positions for Dr. Engel at Cincinnati and Rochester with the idea of a strong liaison between medicine and psychiatry. John Romano was the leading force at Rochester in the teaching of students and the caring for patients with concerns for biology, and the social and psychological factors of disease.

Dr. Romano did not like the name biopsychosocial model and referred to the field as psychosomatic medicine. I find it interesting that Dr. Rosen's article includes the origin of the term biopsychosocial as coming originally from a copy-editor of *Science* magazine. I did not know that story.

David Gilman Romano, PhD
Tucson, AZ

Center for the Study of Tobacco and Society

I am grateful that Dr. Jack Coulehan reviewed the University of Alabama Center for the Study of Tobacco and Society's multimedia exhibitions in the Summer 2019 issue of *The Pharos* (pp. 57–58). I am also appreciative of Dr. Cynthia Burdge's subsequent letter to the editor (*The Pharos*, Winter 2020, p. 59), in which she noted that she had been unable to access on the Center's website https://csts.ua.edu our commemorative exhibition marking the 50th anniversary of the landmark Surgeon General's Report on Smoking and Health.

As a result of Dr. Burdge's letter, we have made it easier to navigate the website and to view our many exhibitions and themed collections. For instance, the 35-slide presentation of highlights of the exhibition "The Surgeon General vs. The Marlboro Man: Who Really Won?" cited by Dr. Coulehan, is available at https://csts.ua.edu/sg-v-mm/ along with a 15-minute video tour of the exhibition when it opened at the Amelia Gayle Gorgas Library at the University of Alabama. (The exhibition was also on view at the Lyndon Baines Johnson Presidential Library and the Texas Medical Center Library.)

In the past year, the Center has produced three new exhibitions which can be viewed online:

- "Sports + Tobacco = A Losing Team" https://csts.ua.edu/sports/
- "Kids, Candy 'n' Cigarettes" https://csts.ua.edu/collections/children-and-tobacco
- "The Unfiltered Truth About Smoking and Health: The AMA Rewrites Tobacco History" https://csts.ua.edu/ama/

With the increase in online learning due to the pandemic, the Center is attracting greater interest among teachers from middle schools to medical schools. Accordingly, we are creating study guides and lesson plans for several of our exhibitions, which are comprised almost entirely of items from the Center's vast collection on the tobacco industry and anti-smoking efforts from throughout the 20th century to the present day.

Alan Blum, MD
AΩA, 1985, Emory University School of Medicine
Director, The University of Alabama Center for the Study of Tobacco and Society

Physicianship and the rebirth of medical education

I trained at Stony Brook University School of Medicine in the 1990s, when the patient, and the patient-doctor relationship, was a prime focus. It was examined through an innovative course, Medicine in Contemporary Society, for which Dr. Coulehan (AΩA, University of Pittsburgh School of Medicine, 1969) was one of the preceptors.

How lucky we were to think about the importance of the patient-doctor relationship early in our training. Humanism in medicine was rewarded. With so many medical reversals, I think the patient-doctor relationship may be one of the most important factors in the healing profession.

Lynne Macco, MD
AΩA, Stony Brook University School of Medicine, 1995
Elizabethtown, NY

Leadership and professionalism in times of crises

After I retired I started a recovery house for women in early recovery from addiction to drugs and alcohol who needed a safe place to work on their recovery. In April, at the height of the pandemic, they had a group activity making banners for community neighbors and putting them up at houses along the street where the recovery house resides.

When their addiction was active these women would not have participated in anything like this. It brought tears to my eyes to see their cooperation and joy in this fulfilling activity.

Dorothy Tompkins, MD, FACC, FASAM
ΑΩΑ, University of Virginia School of Medicine, 1965
North Garden, VA

In Memoriam

Delmar Ralph Aitken (ΑΩΑ, Loma Linda University School of Medicine, 1973, Alumnus) passed away July 29, 2020.

James Aaron Albright (ΑΩΑ, Louisiana State University Health Sciences Center Shreveport, 1990, Faculty) passed away June 2, 2020.

James Algiers (ΑΩΑ, Medical College of Wisconsin, 1953) passed away May 28, 2020.

Robert J. Alteveer (ΑΩΑ, MCP Hahnemann, 1979) passed away August 10, 2020.

Richard D. Amelar (ΑΩΑ, New York University School of Medicine, 1991, Alumnus) passed away September 22, 2020.

Charles "Charley" "CW" Wesley Brandt (ΑΩΑ, Virginia Commonwealth University School of Medicine, 1961) passed away October 11, 2020.

Paul F. Brenner (ΑΩΑ, Keck School of Medicine of the University of Southern California, 1997) passed away July 30, 2020.

George H. Carman (ΑΩΑ, Weill Cornell Medical College, 1950) passed away September 21, 2020.

Calvin Early (ΑΩΑ, The Ohio State University College of Medicine, 1959) passed away March 12, 2020.

Renee Fox (ΑΩΑ, Honorary, 2004) passed away September 23, 2020.

Ronald Fragge (ΑΩΑ, University of Louisville School of Medicine, 1955) passed away September 1, 2020.

Gene N. Herbek (ΑΩΑ, University of Nebraska Medical Center College of Medicine, 2011, Alumnus) passed away June 4, 2020.

Richard Katzman (ΑΩΑ, University of Chicago Pritzker School of Medicine, 1955) passed away October 23, 2019.

Stephen G. Kent (ΑΩΑ, George Washington University School of Medicine and Health Sciences, 1996, Faculty) passed away July 10, 2020.

Thaddeus Kostrubala (ΑΩΑ, University of Virginia School of Medicine, 1958) passed away September 4, 2020.

Dennis J. McCrory (ΑΩΑ, New York University School of Medicine, 1960) passed away July 24, 2020.

John B. McGinty (ΑΩΑ, Tufts University School of Medicine, 1955) passed away November 30, 2019.

Alan Pechacek (ΑΩΑ, University of Iowa Roy J. and Lucille A. Carver College of Medicine) passed away October 18, 2020.

Juan Rosai (ΑΩΑ, University of Minnesota Medical School, 1961, Faculty) passed away July 7, 2020.

Seymour I. Schwartz (ΑΩΑ, New York University School of Medicine, 1950) passed away August 28, 2020.

Wayne C. Spiggle (ΑΩΑ, University of Maryland School of Medicine, 1993, Faculty) passed away July 31, 2020.

Dora A. Stinson (ΑΩΑ, University of Western Ontario Faculty of Medicine and Dentistry, 1961) passed away July 25, 2020.

Lyle E. Wacaser (ΑΩΑ, University of Illinois College of Medicine, 1956) passed away August 14, 2020.

Edwin Walker (ΑΩΑ, Louisiana State University Health New Orleans School of Medicine, 1955) passed away June 19, 2020.

Roscoe C. Young (ΑΩΑ, Howard University College of Medicine, 1956) passed away December 6, 2019.