Letters to the Editor

Repositioning fiscal intermediaries

The lead-off article by Steven H. Lipstein, MHA, and Fred Sanfilippo, MD, PhD (AΩA, Duke University School of Medicine, 1987, Alumnus) (*The Pharos*, Summer 2021, pp. 2–7) is an innovative way to move the needle toward a universal health care system.

I was recently released from a 10-day stay at a university hospital where I received superb care, not only from my physicians, but the entire team of nurses, tech support, diagnostic services personnel, maintenance people, etc. I have not yet received the bill, but I am sure it will be in the six figures. I kept thinking what could be done to lower the cost of my hospitalization, and it was obvious that there is too much duplication of diagnostic testing.

I spent most of my lifetime as a medical educator and director of our family residency program in Lancaster, PA. One of my constant themes to our students and residents is to not order or reorder any test unless you know what you are going to do with the results.

Prior to my admission, my history, along with my imaging studies, warranted the surgery on my heart. Yet, even though these diagnostic studies were performed within one week of my hospitalization and readily accessible, the attending team wanted them repeated. Every day, pre- and postoperatively, I had careful monitoring of my blood count (CBC) and kidney and electrolyte status (BMP & Magnesium). Every day the numbers came back the same except for an adjustment in my potassium and magnesium levels, both arguably still in the normal range.

I kept wondering, couldn't this be done more efficiently. Certainly the CBC did not have to be performed every day, and I wondered, were there other ways to minimize duplication? Being a physician who asked questions, I did manage to avoid some of that duplication. In the end, the cost savings on just what I mentioned, may not amount to more than five percent of my final bill, but that too is significant.

We must find ways to incentivize physicians and hospitals to lower these kinds of costs. The current system rewards hospitals when their doctors order unnecessary or duplicative tests.

I can't wait to see the ideas proposed in the article by Lipstein and Sanfilippo, such as merging Medicaid into Medicare, implemented. It is about time we do something.

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Let's cut out the middleman

I read with sadness the article "Repositioning Fiscal Intermediaries in U.S Health Care," by Steven H. Lipstein, MHA, Fred Sanfilippo, MD, PhD, and Richard L. Byyny, MD, FACP, (*The Pharos* Summer 2021, p 2–7).

The article asks, "Would repositioning fiscal intermediaries…be effective in modifying consumer and provider behaviors to improve health care delivery?" The article explores a single payer system, a capitation system, financial penalties, and price transparency, and notes that these strategies sidestep the question of whether intermediaries are well positioned, and ignores the costs of operating and regulating the fiscal intermediaries.

However, the article does not consider one obvious strategy: the elimination of fiscal intermediaries. Assuming universal health care is a fundamental human right, just as education is a fundamental human right, there could be free clinics and free hospitals, just as there are free public schools. If a patient didn't like pubic health care, they could go to a private physician, just as some people go to private schools.

Dr. Byyny writes, "The system is designed to do what is best for business and a profitable bottom line rather than what is best for patients and society." Insurers, both public and private, are there to make money. But their intrusion into medicine has become toxic. How many patients die while they wait for prior authorization for their treatments? And, does it really matter, as the article points out, that "a number of U.S. citizens are shareholders in these companies," when we're talking about a patient's life? Before repositioning fiscal intermediaries, we have to frankly face their motivations. They profit when the patient dies as they no longer pay for treatment.

Does it matter then, that, "Through the lens of private insurers,…regulation is preferable to a new public option?"

The article speaks of transformational repositioning of intermediaries and the trajectories of health care. That sounds like a lot of syllables, and leads the reader to suspect that the article's authors are glossing over something important. Is abstract jargon used in an effort to diminish the importance of the relationship between a physician and a patient, and thereby to distract one's attention from the intrusion of insurers? The use of terms in the article like "providers," "consumers," and "suppliers," confirms this suspicion.

We might consider fiscal intermediaries as parasites. The migration of fiscal intermediaries, to which the article refers, should be treated in the same way we treat the migration of *Ascaris, Plasmodium,* and *Schistosomiasis*. They've all done enough damage already. To make health care affordable, and to restore the physician-patient relationship, let's not reposition intermediary transformational trajectories. Let's just cut out the middleman.

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Dr. Mary Edwards Walker

Many thanks to Drs. Minor, Stumbar and Anees for their enlightening piece on Dr. Mary Edwards Walker (*The Pharos,* Summer 2021, pp. 9–13), a true pioneer for equity in the medical profession and for women's rights in general. One correction, however, is in order. The Syracuse Medical College from which Dr. Edwards was graduated in 1855 did not evolve into SUNY Upstate Medical University. It only operated from 1850 to 1857, teaching eclectic medicine as described in the article.

The Geneva Medical College (the school that graduated Elizabeth Blackwell in 1848) was founded in 1834 and in 1871 its assets were transferred to Syracuse University, which operated its medical school until 1950 when it became part of the new SUNY system. Thus, the school that is now SUNY Upstate Medical University is careful not to claim Dr. Walker as a graduate, but is proud to celebrate her achievements as part of the rich heritage of women's rights in central New York state. SUNY Upstate takes great pride in having awarded MD degrees not only to Elizabeth Blackwell but also to a distinguished list of women pioneers including Patricia Numann (AΩA, SUNY Upstate Medical University College of Medicine, 1981, Faculty), founder of the Association of Women Surgeons and first female president of the American Board of Surgery, and Nancy Tarbell (AΩA, SUNY Upstate Medical University College of Medicine, 1980), C.C. Wang professor of radiation oncology and dean for academic and clinical affairs at Harvard. Its faculty includes Lynn Cleary (AΩA, The Ohio State University College of Medicine, 1978) president of AΩA Board of Directors.

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St. Francis of Assisi's Fatal Illness

I learned a lot from "St. Francis of Assisi's Fatal Illness: A diagnosis based on alternative forms of intellegence" (*The Pharos*, Summer 2021, pp. 14-18.) However, the authors criticize the 26 percent of crowd-sourcing participants who diagnosed syphilis, claiming they were not aware it was not present in Europe until 1493. That 26 percent may have read the new information on syphilis in Pre-Columbian Europe in *Archeology* magazine, or the *Journal of Biological and Clinical Pathology*. They could also have read my Letter to the Editor published in *The Pharos*, Spring, 2017, p. 53.

Excavations in the cathedral square in St. Polten, Austria, yielded thousands of remains clearly dated to the 14th century, some as early as 1320. The remains were studied at the Center for Anatomy and Cell Biology of the Medical University of Vienna. They found dental abnormalities—Hutchinsons teeth—pathognomonic of congenital syphilis. Columbus apparently brought back a more virulent strain. Clearly syphilis was alive and well and spreading in Europe generations before Columbus.

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Musings on Osler misquoted

David J. Elpern's article (*The Pharos*, Summer 2021, pp. 24–28) fills the need for a peer-reviewed article on things William Osler might have said but that lack documentation.

For *The Quotable Osler* (2003), Mark Silverman (AΩA, Emory University School of Medicine, 1983, Faculty), Jock Murray, and I mined all of Osler's non-technical writings and were double-checked by other members of the American Osler Society. I have yet to identify a choice, highly quotable aphorism by Osler that is not included in that volume. A caveat, however, is that we included the quotations that are only documented in *Sir William Osler: Aphorisms from His Bedside Teachings and Writings, Collected by Robert Bennett Bean, MD* (1874–1944). Some of these possibly reflect sayings that circulated at the Johns Hopkins Hospital and were not original with Osler.

Several times each year I get a request to document where Osler wrote, or when he said, "Listen to the patient, he is telling you the diagnosis." I am aware of just one documentation: the obverse of a medal designed in 1968 by Dr. Masakazu Abe, professor of medicine at the Jikei Medical College, Tokyo. Osler might have said it, but it has been suggested that, on ward rounds, Osler seemed more interested in demonstrating physical findings than in asking open-ended questions of the patient.

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