Timely issue
I want to compliment you on the exception­ally informative, moving and timely issue of Minnesota Medicine. I read every article and learned things for my own practice, for medical education and curriculum, for understanding the Affordable Care Act, and about how a talented fourth-year student subtly unites the science and soul of medicine through the eyes. Thank you.

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Inspiring images
I can’t believe you didn’t credit the artist who did the striking cover and illustrations for the “Comfort of Home” piece. They got me to read the entire issue.

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We agree they’re great. But we purchased them from a stock art company that doesn’t provide the names of individual artists.

From good intentions to inflation, rationing, failure and turmoil
In Dr. David Thorson’s Viewpoint column (December 2012, p. 29), he asked readers to respond to two questions: 1) What do you think of the results of the national survey of attitudes among some 14,000 physicians in which 84 percent thought the profession is in decline? And, 2) What do you think of our profession?

Regarding the survey: Many of my colleagues have felt the same way for some time. The same sense that the profession was in decline was noticeable during the first of two major transitions that have occurred in the nation’s medical sector since the 1960s.

The first transition was the gradual change from a professional medical delivery system to a system dominated by commercial managed care organizations—HMOs—selling prepaid care disguised as insurance. In 1973, those organizations were given the perverse legal power to control use of the benefits they sold.

The trouble started in 1965 with the onset of abrupt medical cost-price inflation (for the first time in nearly 100 years) after passage of Medicare and Medicaid—a turning point when 85 percent of the populace (workers and the old, poor and disabled) suddenly had inexpensive tax-subsidized insurance. The good intention of legislating apparent “free” care paid for by insurance was suddenly followed by ever­lasting demand inflation. It is still considered political suicide to repeal a popular tax subsidy driving demand, thus “necessitating” rationing of supply.

It is no secret that HMOs were created as gatekeepers profit driven to ration use of politically popular tax-subsidized “free” care—the same function performed by socialized national health services abroad.

It is curious that after 1990, when the HMO industry gained control of a significant portion of the money in medicine, it was able to parlay its failure to control costs into unparalleled profits and market power through mergers and acquisitions and then into enormous political power in 2010 with enactment of a more powerful version of managed care: the Patient Protection and Affordable Care Act (PPACA). What is more curious is that the MMA and later the AMA became acolytes of both the first transition from a professional to a commercial system and of the second transition from a commercial to a cartel system.

The second transition was a more abrupt and massive change than the first. It began with the 2010 PPACA “fix” for the commercial HMO industry cost-control failure couched in the rhetoric of “rights” and “accountability.” The law mingles colluding corporate and government authorities into a public cartel system capable of fixing prices (of insurance and services) and franchising only provider gatekeepers in ACO insurance corporations.

“Customers” (businesses and people) are mandated by one cartel partner’s legislation to buy the other partner’s insurance. Government sovereignty shields the cartel from anti-trust, anti-self-referral, and anti-fee-splitting laws, which allows ACO mergers and collusion with HMO corporations to profitably ration care—the ultimate low utilization-driven profiteering big-box medical home. Some pundits predict that in the next decade, after many mergers and acquisitions, only four giant HMO/ACO-government backed “health services” will control the nation’s medical sector.

To explain previous managed care gatekeeper failure and to sell implementation of PPACA “reforms,” government and corporate “payers” make three specious evidence-free claims: First that medical inflation is due to “poor quality” and profligate...
care by culprit clinicians driven to ignoble avarice by an “evil” fee-for-service system. Second, that costs would be contained by transfer of the “payer” gatekeeping role to “culprit” providers by capitation payments for servicing “payer” populations (“payment reform”). Third, that physician gatekeepers could gain redemption, when their avarice is enlisted at the bedside in the more noble cause of conserving society’s “scarce resources”—and by no coincidence, “payer” treasure.

Thus is created a legalized financial conflict of interest between patient and gatekeeping doctor, whose pay is contingent on restricting care under the sophistry of “stewardship.”

Regarding the profession: Is it any wonder that physicians are troubled amidst the turmoil? They run too fast trying to keep up with ballooning patient demand and medical knowledge. They have been demonized and assaulted by political hostility and blunt regulations. They are told that their moral path to salvation is to be “payer” gatekeepers of patient access—another rationing of supply scheme, this time at the bedside.

The pretext of a social good (cost control) is touted to justify questionable means (gatekeeping doctors). This is how professionals and professional medical organizations can lose their claim to patient and public loyalty, the very soul of medicine. It is a story of how patients can lose the protection of law and professionalism.

Amidst the turmoil this is what physicians’ sense has happened to our profession and those we serve. There are alternatives to authoritarian rationing panaceas for medicine’s cost ailment—alternatives that would return power to patients and foster affordable medical insurance. This is where the MMA ought to lead.

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