Continued from page 17

Table. Telemedicine and Direct Diagnoses of Patients with Cutaneous Disease

Patient No.	Patient Age, y	Telemedicine Diagnosis	Direct Diagnosis
1	17	Junctional nevus	Junctional nevus
2	78	Malignant melanoma	Malignant melanoma
3	34	Hand/foot eczema	Hand/foot eczema
4	14	Atopic dermatitis	Atopic dermatitis
5	55	Amyloidosis vs granuloma annulare	Amyloidosis vs granuloma annulare (biopsy: amyloidosis)
6	13	Peutz-Jeghers Syndrome	Peutz-Jeghers syndrome
7	57	Vitiligo	Vitiligo
8	70	Psoriatic nails	Psoriatic nails
9	39	Congenital nevus	Congenital nevus
10	16	Keratosis pilaris vs lichen nitidus	Keratosis pilaris vs lichen nitidus
11	34	Lichen simplex chronicus	Lichen simplex chronicus
12	68	Actinic keratosis	Actinic keratosis
13	62	Eczematous dermatitis	Eczematous dermatitis
14	61	Granuloma annulare vs nodular vasculitis	Granuloma annulare vs nodular vasculitis (biopsy: granuloma annulare)
15	78	Seborrheic keratoses	Seborrheic keratoses
16	57	Chondrodermatitis nodularis helicis	Chondrodermatitis nodularis chronica helicis
17	86	Actinic keratosis	Actinic keratosis
18	67	Post excision of basal cell carcinoma—no recurrence	Post Excision of basal cell carcinoma; no recurrence
19	62	Scleroderma	Scleroderma
20	65	Scar	Scar
21	65	Superficial spreading malignant melanoma and squamous cell carcinoma	Superficial spreading malignant melanoma and squamous cell carcinoma
22	50	Hand eczema vs tinea manuum	Hand eczema

than on direct examination. The examiner reports that although there were some instances in which palpation of lesions might have been helpful in diagnosis, the differential diagnoses were similar even in these cases. Certain lesions, which were not present among our study patients, would require palpation for accurate diagnosis.

Telemedicine technology has been implemented in many fields, allowing specialty care for underserved areas[2] and professional continuing education.[4,5] It is possible that some patients and physicians will be less amenable to health care without direct contact. Some physicians may be concerned about professional liability and compensation for consultations, although in Georgia, Medicare and Medicaid now reimburse for telemedicine charges. Our results in this small patient sample suggest that telemedicine provides a reliable means of evaluating and diagnosing dermatologic problems.

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STRUCTURE AND FINANCING OF HEALTH CARE

To the Editor:

The recently published special article entitled "The Five Generations of American Medical Revolutions"[1] is a useful contribution to the dialogue about the structure and financing of health care in the United States.

The article's characterization of the medical insurance companies as "corrupt" has a certain validity, but perhaps not in the intended sense. This industry has long been caught between two opposing forces. On one side is increasing cost pressure caused by advancing medical technology, the aging of our population, and an increasingly sophisticated medical system with a voracious appetite for dollars. On the other side are the payers (businesses and individuals) who are becoming ever more resistant to underwriting annual cost increases that typically have been two or three times greater than the overall inflation rate. Additional pressures come from consumer advocates, the news media, and the plaintiffs' bar.

As Michael Oakeshott has observed, "Trying to do something which is inherently impossible is always a corrupting exercise."[2] The insurers, having been put in the untenable position of trying to underwrite all the services that physicians favor and patients desire without significantly raising their prices, appear to believe (perhaps with justification) that they must use devious tactics to survive. Rather than vilifying them, we should be looking at the complex pressures they face and contemplating their implications for our future. We ignore, trivialize, or oversimplify the lessons of their experience at great risk.

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1. Garrison RL. The five generations of American medical revolutions. J Fam Pract 1995; 40:281–7.

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The preceding letter was referred to Dr Garrison, who responds as follows:

Dr Gillette notes that medical insurance companies face a complex situation and that we will not design a better system if "we ignore, trivialize, or oversimplify the lessons of their experience." His quotation from Oakeshott is a gem. Nevertheless, recognition of the factors in the insurer's complex situation does not give me sympathy for their predicament, nor does it excuse their choices. When unreasonable, conflicting demands have been made upon them, each time they have said in effect, "No problem. We can do that." They should have said, "That request cannot be accommodated." Beyond that, I have no sympathy for anyone with cash reserves as huge as theirs. They generated those reserves by ruthlessly cutting benefits at a much faster rate than expenses were increasing. In the final analysis, though, the insurance industry is to be condemned because it is not true to its given task. It ought to be, by definition, a risk-sharing mechanism receiving from those who have, in order to distribute to those who have not. Instead, the industry is amassing fortunes at the expense of those with lesser resources, while excluding from the distribution those with least resources.

I doubt that anything pertinent to the discussion is being ignored, trivialized, or oversimplified. The gravity of the situation is all too apparent to me. I have not written about a plan for improvements to the present system but rather about the death of the system.

It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage, than the creation of a new system. For the initiator has enmity of all who would profit by preservation of the old institution, and merely lukewarm defenders in those who would gain by the new one.

—Machiavelli, *The Prince*

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Announcement

The Journal of Family Practice is now online. Our e-mail address is JFAMPRACT@OL.COM. We are pleased to offer this alternative mode of communication to our readership and authors and hope it will enhance your access to the editorial office. All of us on the editorial staff look forward to your continued input and feedback.

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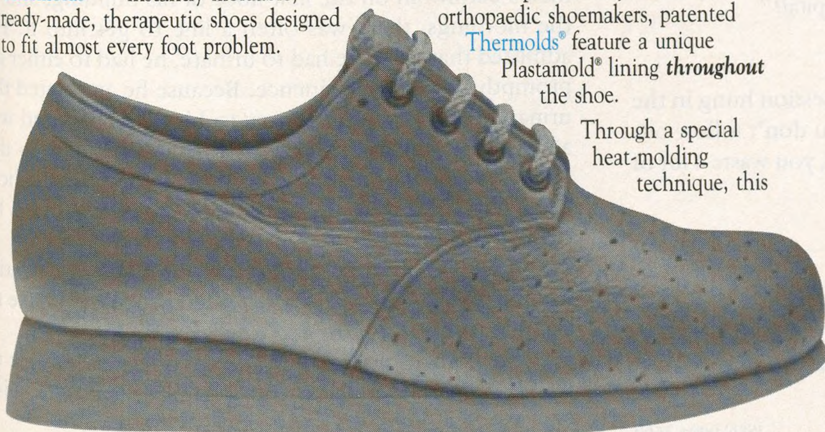

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