Letters to the Editor

Peter E. Dans—A modest man for all seasons

Peter Dans (AΩA, Columbia University Vagelos College of Physicians and Surgeons, 1960) died February 28, 2021, from COVID-19 after a long bout with Parkinson's disease. He was internationally known as an authority on physicians as depicted in motion pictures.

Peter was born into a large Catholic family and grew up in a cold-water flat on the Lower East Side of Manhattan. He won a scholarship to LaSalle Military Academy in Oakdale, New York, from which he graduated valedictorian at age 15. He received his medical degree from the College of Physicians and Surgeons of Columbia University where he was elected to AΩA. He served as an intern and assistant resident on the Osler Service of the Johns Hopkins Hospital, and in 1963 was among the first Osler residents to go to India to study cholera.

In 1964, he joined the staff of the Laboratory of Viral Diseases at the NIH, after which he did a clinical infectious diseases fellowship at the Thorndike Memorial Laboratory of Boston City Hospital's Harvard University Service.

In 1969, he joined the faculty at the University of Colorado Medical Center where he directed the student and employee health services, helped start walk-in clinics including one for seasonal (migrant) farmworkers, and developed a series of films that led to his appointment as editor of "The Physician in the Movies" series in *The Pharos*.

In 1976, he received a Robert Wood Johnson fellowship at the Institute of Medicine of the National Academy of Sciences, where he wrote about the need for more emphasis on care of the aged in medical education.

In 1978, he returned to Johns Hopkins as associate professor of medicine and health policy and management. There he established a course in ethics for first-year students and developed one of the nation's first offices of medical practice evaluation. He later went part-time at Hopkins to become deputy editor for the Annals of Internal Medicine.

Peter told me that as a result of his changing interests—virology, clinical infectious diseases, care for the underserved, care for the elderly, ethics, practice evaluation, and medical writing—he had not stayed in any one national organization long enough to rise to the top. He suggested on another occasion that he never made full professor at Johns Hopkins because he put the interests of his family first.

I treasure my copies of Doctors in the Movies: Boil the Water and Just Say Aah (2000), and Perry's Baltimore Adventure: A Bird's Eye View of Charm City (2003), a children's book inspired by a pair of peregrine falcons that nested on a downtown skyscraper in the city.

Peter was, as I see it, a modest man for all seasons who could do just about anything and who chose to touch as many people's lives in as many ways as he could.

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United States health care system

Thank you for your excellent editorial in *The Pharos* on enacting a U.S. health care system (Spring 2021 issue, p. 2-7).

The extent to which this country has abdicated the basic mission of the medical profession is stark, and many of the more egregious examples are worth noting.

Hypertension is now the leading cause of death in the world.[1] It is easily diagnosed and treatable for a few hundred dollars a year, but in 2017-2018, of the 45 percent of U.S. adults with the diagnosis, only 44 percent were controlled. This is down from 54 percent just four years earlier.[2]

An appendectomy in the U.S. costs between $1,500 and $180,000 with no relation to quality of care.[3]

Mostly because of pharmacy benefit managers, the 90-day cost of the three commonly prescribed generic heart medications in 50-plus contiguous zip code areas outside of St. Louis ranges from $30 to more than $1,145.[4]

A toothbrush in some hospitals costs $1,000.[5]

This fantasy pricing is an attempt to capture the most lucrative reimbursement from the best insurers.

The price of a hip replacement in Belgium at a top facility with comparable outcomes to a good U.S. hospital including travel, lodging, recovery, and rehab is about the cost of the prosthesis alone in the United States.[6] In America, a hospital and the prosthetic manufacturer routinely sign non-disclosure agreements to cost split these $13,000 items. The mark-up at some facilities may be almost three times this. Considering the item costs just $350 to make, it is understandable why some economists refer to the five main American prosthetic manufacturers as a cartel.

Thirty-five percent of spending on drugs in the U.S. is for just two percent of patients. These are specialty or boutique biotech cancer drugs and biologics to treat inflammatory arthropathies or bowel disease. The top-selling drug in the world in 2018 generating $20 billion in sales was a biologic. In the U.S. it costs $38,000 a year. A bioequivalent is available in Europe for 20 percent of the cost, but is mostly unavailable in this country because of

the patent thicket used to protect lucrative drugs.[7] The combination of three first-line disease modifying agents works as well, costing a total of about $90 a month.[8]

In 2017, the market capitalization of the richest health insurer in the U.S.—known in our regional health system for being an extremely bad payor—quintupled since the Affordable Care Act (ACA) was passed.[9] Despite this windfall, it pulled out of 31 of the 34 state health exchanges and bought a chain of emergency surgical centers to leverage the no out-of-network emergency coverage of the ACA. My sister-in-law went to such a place for a few stitches in her finger. The bill was $4,300—completely paid for by her insurance. The procedure would cost about $300 in a primary-care clinic.

Two-thirds of the nation's 5,000 hospitals are now consolidated, up from just half twenty years ago.[10] Despite the economy-of-scale cost savings for the hospitals, and an objective decrease in the quality of care, there is an annual cost increase of six to 10 percent. Insurers and administers of self-insured business are increasingly held hostage to these networks. The Federal Trade Commission is constrained in its reform efforts by outdated antitrust laws and the tax-exempt status of many hospitals.

Tennessee has the highest rate of rural hospital closures per capita in the U.S.—a process increased by a factor of six because of its failure to expand Medicaid.[11] These hospitals could easily house clinics for primary care and women's health, as well as psychological counseling services and drug treatment facilities that have high patient value. Unfortunately, consolidated systems gravitate to the most profitable procedures like elective catheterizations—of questionable value over maximum medical therapy—and joint replacement that benefit a small portion of the population. Investment in basic health care is positively related to labor productivity, personal spending, and increased gross domestic product, and serves as an anchor for business in rural areas.[12] Few significant businesses would locate to a rural county without a hospital.

Students from the area's osteopathic college often rotate through our clinic. Despite obtaining an inferior medical education from schools with less governmental support, they may graduate owing $350,000. Most will enter primary care[13] with an expected starting salary guarantee of about $200,000.[14] Medical school graduates understandably gravitate to high-paying medical specialties and support the status quo. My alma mater state medical school, with a strong mandate to produce primary care physicians, saw only 15 family practice matches from its newly graduated class of 72 physicians.[15]

Except for Luxembourg, the U.S. has the highest physician incomes in the world with one of the greatest disparities between primary care and medical specialist compensation.[16] Many of these specialists have traditionally been complicit in our health care system's systemic problems through their fee-for-service interactions with hospitals.[17] However, some are hapless pawns to the system. For example, my son—a resident in radiation oncology at UF—gave an infusion to a cancer patient that he was surprised to find cost about $40,000.

Who is making these decisions? This is five months of the annual salary of a nurse practitioner who would see 5,000 patient visits a year in an underserved area.[16] Some of the higher-value preventive interactions could save many lives.

Representatives of the professional societies of medical specialists through the AMA's Relative Value Scale Update Committee (RUC) tell the Centers for Medicare and Medicaid Services, as well as private insurers, how much money their physicians should be paid. The inherent bias in this process underrates the cognitive aspect of medicine and the reimbursement model is rapidly changing away from fee-for-service.[18] It is not uncommon for an interventional-structural cardiologist, or a dermatologist who does a lot of Mohs procedures, to make a million dollars a year.[16] Medicine is changing so fast that many of their lucrative procedures are being supplanted by highly accurate external-beam radiation to treat cardiac arrythmias or squamous and basal cell carcinomas of the nose and other cosmetically-sensitive locations.

Despite the high relative value of primary care, 60 percent of health care costs are incurred in hospitals that see eight percent of patients annually while family practices that see 54 percent garner just four percent of the health care dollar.[19]

The benefits to society for universal health care access are greater than most people appreciate. A great deal of new research shows the cyclical nature of health and wealth, one contributing to the other in an increasing manner.[20]

Sometimes the truth is in the details.

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