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**Typesetting and Printing**

Skyline Printing Co., Inc.

Tucson, AZ

**Website**

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Tucson, AZ 85716

*Journal of American Physicians  
and Surgeons* (ISSN 1543-4826)

is published quarterly.

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# Correspondence

## Sham Peer Review

I commend Dr. Huntoon on his informative article on sham peer review.<sup>1</sup> He identified many of the risk factors, including those affecting solo and small-group practitioners, foreign-born physicians, innovators, and physicians whose practices compete with the hospital or influential members of the medical staff.

A few observations: Initiators of sham peer review are usually in larger groups and maintain their power positions in the various committees that start the process or decide on "punishment." The targeted physician usually has a successful and increasing practice that threatens the financial status quo. Complications experienced by patients of the accusers, if their number can be determined, generally exceed those blamed on the accused. Hospital review boards and the peer review system can only handle one review at a time, precluding any meaningful review of the accusers or their associates. As long as the review runs its course, accusers are effectively immune from review themselves.

**Steven Sholem, M.D. M.B.A.**

Phoenix, Ariz.

1. Huntoon LR. Risk factors for sham peer review. *J Am Phys Surg* 2018;23:4-5

## U.S. Medical Spending and OECD

Thanks for publishing the observations by Susan Riggs on the Canadian medical system.<sup>1</sup> It is a welcome antidote to the usual canard, published again in *JAMA*<sup>2</sup> with a number of editorial comments, and referred to in *AAPS News*,<sup>3</sup> that U.S. medical spending per capita is twice that of comparable countries. This is based on data provided by the Organisation for Economic Cooperation and Development (OECD) and reported in the press ad nauseum. The other countries, however, are not "comparable" for many reasons.

First, funds to operate the system in other OECD countries are collected by tax agencies, and the cost of collection is not ascribed to the health system. In the U.S., collection is performed by insurance companies in the form of premiums and by medical practitioners and facilities, and this constitutes about 25 percent of operating costs, which therefore appear to be about 25 percent less in other

OECD countries.

Second, the U.S. has multiple population cohorts that constitute less than 1 percent of the population in OECD countries. These cohorts are very expensive to treat. In the U.S., 13 percent of our people are African-Americans, who, for reasons unknown, suffer up to double the incidence of diabetes, hypertension, and other metabolic disorders, requiring very expensive acute and chronic care: cardiac procedures, amputations, hemodialysis, etc. Many OECD countries are mono-ethnic. In the U.S., 8 percent of our people are military veterans, who often require expensive traumatic, rehabilitative, and psychiatric care. This cohort is often less than 1 percent in OECD countries. Additionally, at least 8 percent of our population is illegal immigrants, who arrive without vetting, with chronic infection, cancer, pregnancies, etc., and are treated at our expense. Our long border with a Third-World country also allows illicit drugs to pour into our cities, creating expensive addiction, promiscuity, and violence. Many OECD countries are islands!

Third, all the other 33 countries have some form of loser-pays tort system as in my native Canada. Depending on which study one believes, defensive medicine can add up to 20 percent to U.S. medical spending, while loser-pays provisions help to contain fraudulent or nuisance lawsuits in other OECD countries.

If OECD statistics were adjusted for accounting, demographics, and tort, U.S. spending would be comparable to other countries and maybe even less. I have written dozens of letters in response to "social scientists" who constantly repeat the claim that the U.S. spends twice as much without better results. I have never received a reply or a challenge. Big-government advocates will not answer. They know that comparing apples and oranges is easy. But it is illogical and invalid.

**Calvin Ennis, M.D.**

Pascagoula, Miss.

1. Riggs S. The human cost of healthcare: but it's free in Canada. *J Am Phys Surg* 2018;23:26-28.
2. Papanicolaos I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. *JAMA* 2018;319:1024-1029.
3. AAPS. Safe kickbacks. *AAPS News* 2018;74(4):1. Available at: <https://aapsonline.org/aaps-news-april-2018-safe-kickbacks/>. Accessed May 23, 2018.