

## Reviews and reflections



### On the Shoulders of Giants: What Today's Clinicians Can Learn from Yesterday's Wisdom

Robert B. Taylor  
New York, Springer, 2015.

Reviewed by Jack Coulehan, MD  
(AQA, University of Pittsburgh, 1969)

If I have seen further, it is by standing on the shoulders of giants." This statement is usually referenced to a letter Isaac Newton wrote to his fellow scientist (and rival) Robert Hooke in 1676. Although the sentiment did not originate with Newton, its attribution to him is compelling because of the seeming paradox: one of the greatest scientists of all time expresses a sense of profound humility. This seems strange to us because humility is not a highly regarded virtue in today's science. And certainly not a big feature of contemporary medicine. Thus, Robert B. Taylor's new book, *On*

*the Shoulders of Giants: What Today's Clinicians Can Learn from Yesterday's Wisdom*, is timely and refreshing.

Taylor presents the reader with quotations (or "pearls," if you will) from the works of numerous historical physicians, philosophers, sociologists, and others regarding various topics related to medicine: professionalism, doctoring, health, illness, diagnosis, therapy, and so forth. In each case the author gives us a short reflection that suggests lessons clinicians of today can learn from the wisdom of these "giants." Most of these reflections are illustrated with appropriate images, usually the giant himself—or, in a very few cases, herself. Taylor's pearls are drawn from the works of eminent physicians like Hippocrates, Maimonides, William Heberden, Rudolph Virchow, Elizabeth Blackwell, William Osler, Sigmund Freud, Harvey Cushing, Joseph Lister, Wilder Penfield, Lewis Thomas, Michael DeBakey, and Ed Pellegrino; as well as notable non-physician writers ranging from ancient philosophers such as Aristotle and Seneca, to contemporary medical sociologist Paul Starr.

The reader will find great richness in these texts and commentaries. For example, the second half of the final sentence of Dr. Francis Peabody's famous 1927 *JAMA* article is widely quoted in medical education, "the secret of the care of the patient is in caring for

the patient." This is a meaningful and memorable play on words, but rather nonspecific advice. However, Dr. Taylor shows that the educational impact can be much greater by citing the whole final paragraph:

The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.<sup>p68</sup>

This more complete text links care to empathic understanding and the physician-patient bond to professional satisfaction. A far wiser pearl!

Another welcome insight comes from Dr. Arthur Hertzler's memoir, *The Horse and Buggy Doctor* (1938). Hertzler was a general practitioner and surgeon in a small Kansas town during the early twentieth century. On the importance of medical history-taking, he wrote:

The securing of an adequate one is a work of art. It requires a knowledge of disease and of human nature. It is hard work and is time consuming

but it is necessary because in many cases it is the most important factor in the whole procedure.<sup>p122</sup>

The concept of the history as a doctor's work of art reminds us that oftentimes it is the physician and not the patient who is a "poor historian." Likewise, in these days of controversy over apologies to patients for medical errors, it is refreshing to read Sir Joseph Lister's forthright statement: "Next to the promulgation of the truth, the best thing I can conceive that a man can do is the public recantation of an error."<sup>p198</sup>

However, a few of the sayings are curiously dated, if not intrinsically overblown. For example, Susruta, one of the first systematizers of Ayurvedic medicine (about 600 BCE), wrote that the patient "should put his own life into [the physician's] hands without the least apprehension of danger; hence a physician should protect his patient as his own begotten child."<sup>p28</sup> This very strong version of paternalism has no place in contemporary medicine, and its advice to dismiss "the least apprehension of danger" strikes a false note in this time of excessive testing, inappropriate surgery, and abuse by insurance providers. Taylor's commentary dwells on the physician's duty to protect the patient from such practices. Perfectly true. Unfortunately, though, in many cases physicians themselves perpetrate these harms. Educated caution, not mindless embrace, seems a better injunction.

In another example, Taylor quotes Plato's vision of the ideal society where:

No physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient: for the true physician is also a ruler, having the human body as his subject, and is not a mere moneymaker.<sup>p6</sup>

The reminder here, well-articulated in Taylor's comments, is that even in ancient Athens the lure of self-interest and personal gain could compromise

professional ethics. He cites a number of recent examples of conflict of interest in medicine and even outright criminal activity, the most dramatic of which is the \$4.8 billion of fraudulent billing by 1,400 physicians discovered by the Medicare Fraud Strike Force.

Finally, a quotation from Paul Starr's *The Social Transformation of American Medicine* raises the question of reason versus "power" in medical practice. Starr wrote:

The dream of reason did not take power into account. The dream was that reason, in the form of the arts and sciences, would liberate humanity from scarcity and the caprices of nature, ignorance and superstition, tyranny, and not the least of all, the diseases of the body and the spirit.<sup>p20</sup>

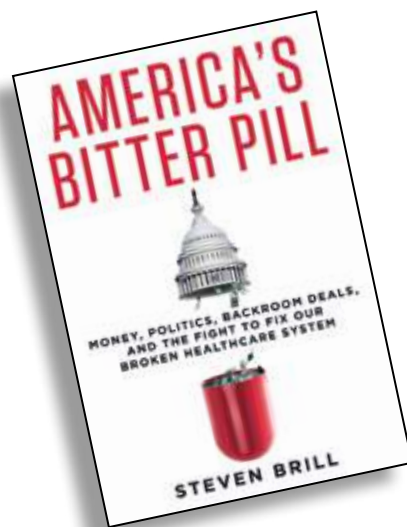
However, stipulating a dichotomy between reason and power can be very misleading since it is, in fact, the power of reason that drives science. Moreover, medical power derives not only from science, but also from cultural beliefs, institutional influence, patient expectations, and the physician's own charisma. Pharmaceutical companies, for example, exhibit massive influence on medical practice. Thus, when Dr. Taylor writes that the Affordable Care Act (ACA) of 2010 "represents the greatest transformation of the profession and exercise of raw power in the history of American medicine,"<sup>p21</sup> I'm skeptical. What about Medicare? What about rapid technological change? What about our subservience to the pharmaceutical industry? Frankly, I don't think an attempt to make American health care more equitable and accountable deserves the appellation "raw power," unless your definition of raw power includes the democratic process.

*On the Shoulders of Giants* is a richly wise and provocative resource that will appeal to students, physicians, and anyone interested in the relevance of medical history and tradition to today's practice. I found it fascinating to re-

visit the words of many old friends and, especially, to learn new insights from thinkers I had never before encountered. In medicine it's true that learning is a lifelong process.

Dr. Coulehan is a member of the editorial board of *The Pharos* and one of its book review editors. His address is:

Center for Medical Humanities,  
Compassionate Care, and Bioethics  
Stony Brook University  
Stony Brook, New York 11794-8335  
E-mail: John.Coulehan@  
stonybrookmedicine.edu



### **America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System**

Steven Brill  
New York, Random House, 2015,  
528 pages

**Reviewed by Nick Estes, JD**

Steven Brill is the author of the terrific exposé in *Time Magazine* about the high cost of American health care. Brill is a wonderful reporter and storyteller, and believe it or not, this book is a page turner, especially for those of us who have followed the saga of

Obamacare at a distance. This is the inside story of its adoption and implementation, and it's fascinating and appalling at the same time.

Two central facts jump out at me in reading about the drama of getting health care reform adopted in America: the unbelievable political power of the health care industry and the fact that sixty votes are required to pass anything in the United States Senate. What challenges!

Health care is the largest business in the United States, weighing in at over \$3 trillion per year. That will buy you a lot of lobbyists, and health care has far more than any other industry. Their tracks are all over Obamacare, and this compelling book recounts how they got there.

Imagine: in the face of universal concern about health care costs, Obamacare preserves the prohibition on Medicare negotiating volume discounts with the all-powerful drug companies. Imagine: Obamacare establishes a comparative effectiveness review mechanism, but forbids Medicare from relying on its findings when determining what procedures and drugs it will cover. These are typical of the Faustian bargains felt necessary to get this bill passed.

The Senate's filibuster rule amplified the power of the industry by making its support so essential. Democrats comfortably controlled both the House of Representatives and the Senate (60-40 in the latter case). But they had to get every one of those Senate votes. So special inducements like the "Cornhusker Kickback" (so blatant it was ultimately eliminated) were necessary even to keep the Democrats on board.

The sixty-vote rule almost killed Obamacare completely after Ted Kennedy died and was replaced by Republican Scott Brown. The Senate had passed a bill but it wasn't liberal enough for the House. After Kennedy's death it wasn't clear how the Senate could pass a bill splitting the difference. Ultimately the Senate compromises had to be put into a separate bill that focused on the financial provisions, so

that the Senate could pass it under the "reconciliation" rules that permit closing debate on budget bills with a simple majority vote.

One result was that inadvertent language was left in the final bill that seemed to restrict federal subsidies to buy private insurance on the new "exchanges." This gave Republican opponents an opening for the lawsuit ultimately rejected by the Supreme Court that would have gutted an important aspect of Obamacare. (The court ruled in June that the subsidies imperiled by the lawsuit were valid.) It wouldn't have happened if the Senate could have passed a cleaned-up bill by a simple majority vote.

Then we've got the saga of the disastrous implementation. Once again, Brill tells a fascinating but appalling story. The inability of different parts of the government to communicate with each other was incredible to me. Brill makes a convincing case that neither Obama nor Health and Human Services Secretary Sibelius had any idea prior to the rollout that the experts in charge knew the website needed much more testing and was likely to be a spectacular failure.

Think of that. It's as if FDR and George Marshall had been so removed from the D-Day planning that they wouldn't have known if most of the generals had been privately grumbling that the invasion was almost certain to fail. Good leaders figure out ways to make sure they know what's really happening on the ground.

On the other hand, the tale of the fixing the website is fascinating and uplifting. Experts, mostly but not all from the private sector, jumped into the mess and worked virtually around the clock for two months, many of them for no pay, to get the website repaired. Americans can certainly rise to the occasion.

As Brill recounts, the Obamacare negotiators abandoned any serious effort to deal with the ridiculously high cost of American health care (so well documented in his *Time* article). So in the final section of the book, Brill proposes

his own solution. He dismisses as politically hopeless the "single-payer" solution adopted in every other advanced country, where the single-payer (usually the government) uses its regulatory and bargaining power to control health care costs directly.

Instead, he suggests we encourage a couple of large health care providers in each "market" to start their own insurance companies so that the people providing the care work for the same entities that pay for it (like at Kaiser Permanente in California). He argues that this would at least eliminate the costs of providers arguing with insurers, which are certainly substantial. He recognizes that providers who work for entities that also are insurers have major incentives to minimize expensive care, but he proposes that quality-control regulations be beefed up to deal with that obvious problem.

I agree with the Dr. John Geyman's assessment in *How Obamacare is Unsustainable* that this approach is unlikely to have much cost impact, since it leaves private companies with even less competition and with every incentive to make money running the show. I agree with Brill that it will probably be a long time before we take the sensible step of expanding Medicare to cover everyone.

The book might have been better to recognize that, in the meantime, perhaps there is a good old American solution to handling high costs: encourage more competition in the provision of medicine. For example, we might reduce the barriers that limit how many foreign-trained physicians may practice here. We might publicly finance medical education and expand residency programs. We could allow Medicare to bargain with the drug companies and allow medicine to be freely imported from Canada and elsewhere.

One reason health care in America is so expensive is because there are many anti-competitive arrangements that keep prices higher than they might be. Maybe we will ultimately deal with this in a very American way if people

like Stephen Brill keep writing good books and articles telling us all what's going on.

Mr. Estes is the former health policy analyst for New Mexico Voices for Children. His address is:

1315 Lobo Place NE  
Albuquerque, New Mexico 87106  
E-mail: nestes@unm.edu



### How Obamacare Is Unsustainable: Why We Need a Single-Payer Solution for All Americans

John Geyman, MD  
Friday Harbor, Washington, Copernicus Health Care, 2015, 328 pages

Reviewed by Nick Estes, JD

It's been five years since passage of the Affordable Care Act and over 30 million people have obtained health insurance coverage—most for the first time. The national uninsured rate has declined from a peak of eighteen percent to eleven percent. Low-income individuals have benefited from the expansion of Medicaid (in about half the states) and from the premium subsidies for private coverage purchased on the new health insurance exchanges. Obamacare brought major reforms to our health insurance system: carriers can't deny people because of pre-existing conditions, annual and lifetime caps on benefits are not allowed, and young adults can stay on their parents' policies until age twenty-six. The ACA, together with

a reviving economy, even seems to have bent the cost curve down somewhat.

So what's not to like?

Plenty, according to Dr. John Geyman in *How Obamacare Is Unsustainable: Why We Need a Single-Payer Solution for All Americans*. Dr. Geyman makes a compelling and well-written case that America could do much better for its citizens.

First, 30 million people are still uninsured under the ACA. This would be unimaginable in other advanced countries. And there is little hope that many more of these individuals will become insured. Many of them are low-income individuals who are just above the income cut-off for Medicaid, but feel they can't afford the coverage offered on the exchanges—even with a federal subsidy—and are willing to take their chances with a tax penalty—or with a sudden serious illness.

Moreover, even for those with insurance, Dr. Geyman emphasizes that an "epidemic of underinsurance" has developed. Many employer-sponsored health plans (some adopted to meet ACA requirements), as well as individual plans, including many purchased on the new state exchanges, have higher and higher deductibles and co-pays. For example, most people are buying "silver" plans on their exchange, which only cover seventy percent of the enrollee's medical bills. Many are buying "bronze" plans, which cover sixty percent. Obviously, a family could easily be financially devastated by having to pay thirty or forty percent of the cost of treatment for a really serious illness.

Moreover, health care remains twice as expensive per capita in the United States as the average of other advanced countries, while health outcomes are not any better, and are frequently worse. Obamacare is only expected to cause marginal improvement in that unconscionable statistic.

According to the Dr. Geyman, the basic problem with the ACA is that it is built on our current system of private health insurance, which costs a for-

tune in administration and profits, while adding essentially nothing of value to American health care. The incredible political power of the health care industry, and especially the health insurance industry, forced the politicians, from President Obama on down, to exclude any consideration of a "single-payer" system like Medicare, in which citizens pay taxes rather than insurance premiums, and a government agency, rather than private companies, pay the health care providers.

I was startled to learn from Dr. Geyman that the excess administrative costs attributable to our system of private health insurance (both at the insurance carriers and at hospitals and physician offices) currently are almost \$600 billion per year—over three percent of our nation's gross domestic product. That's almost twenty percent of our total health care costs. The administrative costs of Medicare, by contrast, are about three percent.

For all this money, there is no evidence that the health insurance companies provide any useful service that couldn't be provided just as well by a government agency like the Centers for Medicare and Medicaid Services at much lower cost.

There are two functions of health insurance. First, the insurance function. Someone must collect funds on a regular basis from a large pool, and then use those funds to cover at least some of the health care costs of individuals when they occur, recognizing that some people every year will need far more health care than others. A government agency can provide this risk-smoothing function as well as hundreds of private companies, as Medicare does now for our highest-risk population. Second, there is the administrative function: managing the collection of premiums and the payment of health care costs to the providers, minus co-pays and deductibles. To keep payment costs down, the insurance companies bargain with providers and limit access in various ways, so they can guarantee providers

certain volumes of business in exchange for lower rates.

The core problem with this system is that it takes huge costs to administer a system that requires each company and provider to determine which costs are covered—and that will depend on the patient's particular plan, on which entity provided the service, what type of service was provided, and under what circumstances. In the meantime, the company has every incentive to find ways to maximize the costs borne by the provider and the patient, and minimize what it must pay. These limitations on coverage cause people to skip preventive, non-emergency care, and wait until they are really sick and have to go to the emergency room at great expense.

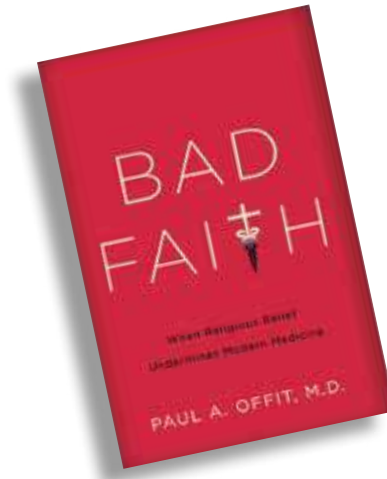
Dr. Geyman argues very persuasively that it is high time we recognized that provision of medical care is not primarily a “business” best left to the private market, because everyone deserves good care regardless of their income level. Most advanced countries combine a system of mostly private providers with a form of universal national health insurance ultimately supported by income and payroll taxes. Canada is an example. (The United Kingdom is unusual in providing most care through a national health service that actually employs the physicians.)

This book is a very informative, clearly written, comprehensive indictment of our present health care system, five years into Obamacare. Personally, however, I doubt that the system is as “unsustainable” as Dr. Geyman thinks. American politics is remarkably adept at resisting changes that threaten the incomes of powerful interests. Thirty years ago, when health care spending was less than ten percent of GDP, everyone would have said that a spending level that consumed eighteen percent of our GDP surely would never be allowed. Today we think that surely Americans will wake up and adopt national health insurance as health care spending approaches and then exceeds twenty

percent of our income. I'm not holding my breath.

Mr. Estes is the former health policy analyst for New Mexico Voices for Children. His address is:

1315 Lobo Place NE  
Albuquerque, New Mexico 87106  
E-mail: nestes@unm.edu



### **Bad Faith: When Religious Belief Undermines Modern Medicine**

Paul A. Offit

Basic Books, New York, 2015,  
253 pages

**Reviewed by Allan J. Jacobs, MD,  
JD (AΩA, University of Southern  
California, 1972)**

**P**aul Offit is an eminent physician, a crusader for children's health, and a hero. He is a professor of Pediatrics at the University of Pennsylvania, where he holds an endowed chairmanship. By developing the rotovirus vaccine he has saved more lives than most entire medical school classes. He has campaigned extensively to promote childhood vaccination. This crusade has earned him the enmity of anti-vaccine activists, and death threats of violence from some of them. He also has crusaded against

unproven remedies, including dietary supplements.

In his latest book, Offit argues against religious practices that ignore medical facts as primary treatment of serious disease. *Bad Faith* presents gripping anecdotes of women and children who have died because they did not receive vaccinations against serious illness or obtain medical care for life-threatening infections or injury. The author's passion burns on every page. The book centers on faith healing and vaccination refusal. It describes parents who, under religious influence, watch their children die or suffer irreversible damage rather than take them to a physician. Court intervention is insufficient because the children often are too far gone when authorities learn of their illness.

It seems almost churlish to criticize a book written by a famous, heroic author seeking to address this deplorable treatment of children. However, this book suffers from some flaws that detract from the strength of the author's arguments

The first is its overbroad proposed solution. This is to abolish religious exemptions from child neglect and child abuse legislation.<sup>p183-87</sup> It is appropriate to consider denial of care for serious illnesses, including vaccination, as abuse. Criminalization may not be as appropriate for lesser parental failures, though. I, like many parents, have agonized over when to take a febrile child to a pediatrician. However, a delay by a poorly educated fundamentalist would be more likely to attract the attention of a prosecutor than would a similar delay by educated professionals.

A second weakness in Offit's presentation is his condemnation of orogenital suction during circumcision and laws prohibiting pregnancy termination when a woman's health is at stake. The former is a practice of especially strict groups of Orthodox Jews, while the latter legislation was enacted in Ireland under Catholic influence. These practices may be valid health concerns, but

are not directly germane to the book's basic issue, which is that some religious groups withhold medical care from children. Offit's advocacy is not served by opposing people such as Catholics and Orthodox Jews, who mostly support provision of medical care to children.

Most important, though, is that Offit's understanding of religion is incomplete. He views religion instrumentally: it is good to the extent it promotes secular well-being. To be truly religious "is to be humane."<sup>pxiii</sup> Offit, who says he is nonreligious but ethnically Jewish,<sup>1</sup> describes an Orthodox Jewish doctor as being faced with two "conflicting ideologies": his religion and "scientific and medical training."<sup>p73</sup> Neither medical training nor science itself is an ideology, however. Secular choices themselves may also reflect conflicts with the value of health, such as taking the risk inherent in cosmetic procedures. The ideological consideration is deciding when religion should take priority over health, and vice versa. Physicians certainly should be committed to furthering health, but their patients often can appropriately prioritize other values.

Religious people do not regard their faith and practices primarily as a way to improve their material circumstances, though. Religion involves belief in an order outside of nature. Religious doctrine may hold that there are rewards for compliance with this order, and punishment for noncompliance. Some religions emphasize the fate of the personality after death, while others seek primarily to organize society in accordance with a divine blueprint. To these ends, religions espouse three major concepts that are in conflict with material goals. These are martyrdom, renunciation of physical goods, and prophetic outlook. Most major religions regard death as preferable to abandonment of the faith under compulsion. Most also require some degree of physical renunciation, such as sexual restraint or dietary restrictions. Finally, religious adherents

may bear witness to the perceived failings of society, its leaders, and its institutions. From Samuel's criticism of King Saul's misrule to Martin Luther King's condemnation of American segregation, this prophetic outlook has been integral to the Judeo-Christian tradition. Criticism may come from different perspectives; the critical perspectives of William Sloan Coffin and Jerry Falwell are radically different. A prophetic outlook is not necessarily correct. It can be bizarre, as with the faith healers Offit describes; or even vile, like that of Fred Phelps. Which of these, if any, reflect true religion is uncertain, but certainly all are truly religion.

Offit gives insufficient credit to major religions' support for medical care. His portrayals of Judaism and Catholicism do not explicitly acknowledge that both traditions normatively regard medical care as the preferred treatment for physical illness. Not only Jews and Catholics, but members of most religions, may pray for recovery while simultaneously pursuing medical treatment. Although Catholic doctrine accepts intercession of saints, this is considered a last resort. And Western Jews not only have relied on medicine, but have disproportionately become physicians, while most sizeable modern Jewish communities have built hospitals. Conflating ancient Israelite with modern Jewish practice, Offit cites Biblical passages that attribute illness to divine visitation.<sup>p114</sup> Offit also misunderstands the Israelite practice of "ritual child murder;"<sup>p122</sup> even in ancient times child sacrifice was considered abhorrent.

Offit also offers an incomplete, instrumental view of law.<sup>p148-61</sup> He seems to construe the significance of Supreme Court cases as being the way the dispute at hand is resolved. The justices, however, are more concerned with the general legal rules that will serve as precedents for future cases in many courts, applied to a wide range of facts. *Bad Faith* ignores these legal rules. So

Offit sees *Church of Lukumi Babalu Aye v. City of Hialeah* (1993) as being about animal sacrifice, rather than as about the power of government to enact laws that target specific religions using a secular pretext. He sees *Burwell v. Hobby Lobby* (2014) as addressing post-coital contraception, rather than the question of what rights individuals must give up when they operate their businesses as a corporation. The Court strives to make the rules come out right rather than to make the resolution of the facts come out right. Most of us probably would prefer to be judged under reasonably fair and predictable rules rather than take our chances that we will appear before a judge whose social and political opinions agree with our needs.

*Bad Faith* makes a strong case for government action against reliance on faith healing in children instead of medicine. The book would be even more persuasive if it exhibited a better understanding of religion and law.

#### Reference

1. Berger E. CHOP doc gives inoculation his best shot. Jewish Exponent 2015 Feb 18. <http://www.jewishexponent.com/headlines/2015/02/chop-doc-gives-inoculation-his-best-shot>.

Allan J. Jacobs is Director of Gynecologic Oncology, Coney Island Hospital, Brooklyn, New York, and Professor of Obstetrics and Gynecology and Affiliated Faculty, Center for Medical Humanities, Compassionate Care, and Bioethics, Department of Preventive Medicine, Stony Brook University School of Medicine, Stony Brook, New York. His address is:

Department of Obstetrics and  
Gynecology  
Coney Island Hospital  
2601 Ocean Parkway  
Brooklyn, New York 11235  
E-mail: allanjoeljacobsgmail.com