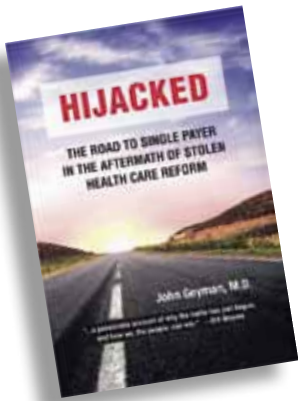


Reviews and reflections

David A. Bennahum, MD, and Jack Coulehan, MD, Book Review Editors



Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform

John Geyman, MD
Monroe, Maine, Common Courage Press, 2010, 290 pages

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

Hijacked, the most recent of John Geyman's critical explorations of the American health care system, combines extensive documentation, reasonable argument, and rhetorical passion. Geyman, an eminent academic family physician and former president of Physicians for a National Health Program, initiated his analyses in 2001 with *Health Care in America: Can Our Ailing System Be Healed?* and has subsequently published books on health care inequities, corporate medicine, health insurance, and the decline of moral and professional values in medicine. The present book, Geyman's response to the Patient Protection and Affordable Care Act of 2010, summarizes its theme in the subtitle, *The Road to Single Payer in the Aftermath of Stolen Health Care Reform*.

The word "stolen" will resonate with many Americans who, like me, believed that Barack Obama's election in 2008 had opened a window for genuine change. Obama the candidate had

clearly articulated the need to achieve three major goals in health care reform: decreased costs, improved quality, and universal coverage. And the voters had evidently agreed. I realized that the country was divided between those who viewed a single-payer system as the only way to achieve reform and their opponents who violently disagreed and argued that modifications of the existing health insurance system would suffice, and I anticipated serious and energetic debate. As it turned out, neither Democrats nor Republicans demonstrated the political courage to seize the day. The debate degenerated into a quagmire of complexity, misinformation, and fear. It was remarkable, under these circumstances, that Congress did, in fact, manage to pass the Patient Protection and Affordable Care Act of 2010. But, according to Geyman, the limitations and complexity of that legislation raise two burning questions: Why and how did we squander our best shot at genuine reform? And is the reform they enacted better than nothing?

Geyman contends that both political parties bear some responsibility for stealing reform. The Obama administration shot itself in the foot at the outset by framing the discussion to exclude a single-payer system. It failed to play its strongest card, a system simple to understand and with an established track record throughout the world. Perhaps not politically acceptable in its entirety, but a strong opening position. However, in his desire to appear "moderate" and obtain Republican support, Obama ruled out single-payer, which almost guaranteed that universal coverage would be prohibitively expensive. Rather, the administration squandered its momentum on the relatively weak idea of a "public option" to compete with private insurers as a method of achieving cost savings.

The second mistake the author attributes to the president was his highly touted attempt to co-opt health care stakeholders by getting hospitals, organized medicine, big pharma, and the

health insurance industry to buy into his reform initiative. Obama believed that by bringing these players into the fold and giving them good publicity for their public spiritedness, he could induce them to partially set aside self-interest in the interest of the public. Wrong! The insurance industry was happy to support universal coverage, given the prospect of millions of new enrollees, but it lobbied against effective cost controls. At the same time, "the top five insurers in the country rung up \$12 billion in profits in 2009 while dropping 2.7 million enrollees."^{p14} Likewise, the pharmaceutical industry loudly pledged \$80 billion toward health care reform, while at the same time raising its prices by nine percent over the previous year, a price increase supposedly justified by costs of research and development, even though the industry "spends two to three times more on marketing than it does on research and development."^{p21} In other words, the price of these stakeholders' endorsements was to weaken comprehensiveness and introduce additional barriers to reform, like agreeing to avoid negotiating drug prices.

The Republican response was essentially to stonewall, a mixture of no compromise and no ideas. It became quite clear, Geyman claims, that the chief Republican goal was not to offer a principled conservative approach to health care reform, but rather to prevent the president's success at all costs. First, they squelched the "public option." Then they exploited both the real and imagined weaknesses of Democratic plans by a high-pitched campaign of disinformation. Finally, they employed the undemocratic Senate cloture rule to block legislation there.

In a chapter subtitled "Better Than Nothing?" the author presents his analysis of the net worth of the new system. On the positive side, the act will extend health care to 32 million more people by 2019, phase out the "doughnut hole" coverage gap for Medicare prescription drug benefit, and initiate certain significant reforms of the insurance industry,



like prohibiting exclusions for preexisting conditions and banning annual and lifetime coverage limits. However, most of the increased cost of these “positives” has no clear-cut linkage to cost-reduction strategies. The bottom line, according to Geyman, is that the cost of health care will continue to skyrocket, while the goal of universal coverage will also not fully be attained.

Geyman presents the reader with eleven major lessons from Obama’s health reform effort. Several of these seem self-evident, e.g., the quest for bipartisanship was futile; real reform was considered politically infeasible; health care is not just another commodity; and Senate rules blocked the democratic process. (This refers to the Senate’s cloture rule that requires a super-majority of sixty percent to bring any bill to a vote. It means that forty-one senators can—and did—block legislation supported by a majority of both houses of Congress and the president.) A few of Geyman’s lessons are more controversial, i.e., “the private health insurance industry is in a death spiral and does not provide enough value to justify a bailout.”^{p183} This is a position that is supported by the evidence in my opinion, but obviously many would argue otherwise. Similarly, the final lesson that “health care reform must be fundamental and comprehensive with a simplified financing system” is not one that the majority of our senators and representatives—especially as of November 3, 2010—agree with.

The great value of *Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform* derives from Geyman’s ability to marshal overwhelming evidence and then present his arguments with clarity and passion. The book is “trenchant and highly readable,” as Marcia Angell comments in her blurb. It is also sobering and somewhat depressing. Nonetheless, it is a must-read for anyone who seeks a better understanding of the problems facing American health care reform in 2011.

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La Clinica: A Doctor’s Journey Across Borders

David P. Sklar
University of New Mexico Press,
Albuquerque, New Mexico, 2010,
248 pages

**Reviewed by Robert H. Moser, MD
(AΩA, Georgetown University, 1969)**

I found this book to be subtly disquieting, to the extent that I read it again. It is a quasi-autobiographical story in which the author, David Sklar, frequently uses quotations from individuals he encountered up to twenty years ago. This device makes for dramatic rhetoric (and some “literary license” is acceptable), but the extent to which this device is deployed challenges credibility.

It would seem quite rare in medicine that an encounter that occurred before entering medical school would have a profound and prolonged influence on one’s professional and personal philosophy of life. Yet this is the central thesis of *La Clinica*.

Upon completion of his college years,

Sklar was contacted by Carl Wilson, who operated a primitive medical clinic in the Sierra Madre region of Mexico. Wilson emerges as an enigmatic, charismatic central figure. For many years he has been the sole “physician” caring for the poor farmers of the village and surrounding area. Subsequently it is discovered that he is not a licensed physician, but a bright, highly-motivated autodidact who devours medical books. His nationality is not disclosed, but he is fluent in Spanish and embraces his role as a healer. (The villagers never challenge his credentials and eagerly accept him—attributing god-like qualities to him.) Also, to compound the complexity of this character, he can best be described as a “benign” pederast (my oxymoronic term). He exploits adolescents, but also helps with their education and aids in their pursuit of a better life outside the stifling village environment.

The Mexican adventure begins when Sklar responds to a call for professional help from Wilson and goes to work in the clinic for about six months. His only preparation is a crash course in suturing and some exposure to a physician’s assistant program. Suddenly he finds himself thrust into caring for some very ill patients with little or no guidance from Wilson, few tools, and a very primitive (dirt floors) physical facility.

The story evolves in a rather convoluted fashion. Apparently, it was written while Sklar was chief of emergency medicine in a university hospital. As the author describes his rather quotidian present life in Albuquerque (mostly concerning events in the emergency room), he interjects frequent recollections of his time in Mexico—over twenty years back.

Even though I was only twenty-two years old and was not yet a doctor, and even though I barely understood their language, they would come to my window in the night.

And I’d dress and stumble over the uneven rocks of the unlit street to an adobe house with a single lantern illuminating a feverish patient lying on a burlap cot in the darkest

corner of the room. I'd smell the strange pungent herbs and oils covering a place where the pain resided, usually in the middle of the belly or under a breast.

After a while they'd whisper my name again. "David, David is there no medicine for this?"

And I'd have to walk back across the village to the clinic to find something that might help.^{P2}

This statement would epitomize his time in Mexico.

In essence, Carl (who was totally disenchanted with the world of organized medicine, where he saw avarice, lack of caring, and corruption of ethical values), preached his gospel that care of sick patients could be done by anyone motivated to provide succor and comfort with even minimal medical skills. This philosophy was largely enabled by the local population who were culturally adapted to low expectations for relief or cure and believed that ultimate survival of an individual was in God's hands. They utilized the services of witch-like *curanderos*, who relied on incantations, charms, and spells. Sklar devotes too little text to a discussion of his interface with local healers.

His ability to help the villagers is facilitated by the low expectations of his patients and their belief that the *gringo* doctor can do magic things by simply being present and laying on hands. Since most symptoms have a major psychological component, such success is not unusual.

As Sklar writes,

In those days, I carried with me a bag of equipment, a light, some pills, and a conviction that, whatever gaps in my knowledge, I was better than nothing; I could make a difference. Now I wondered what had made me so sure and why I hadn't questioned myself—questioned all of us there—for pretending to know more or be more than we were.^{P3}

It would seem a prime example of the

wisdom of the aphorism, "In the land of the blind the one-eyed man is king."

One cannot help being dismayed by Sklar's abiding insecurity and depression in his professional and personal life. It permeates the entire text. Too frequently (for me) he indulges in painful introspection—almost confessional in intimacy. His wife has left him taking their two children, which has a devastating impact. We never learn why.

He describes his two return visits to the village—once with his new bride and then twenty-odd years later. In the interim, Carl has significantly improved life in the village (running fresh water, electricity, waste disposal). He has become an international lecturer on how to set up and operate a rural clinic. But after twenty-five years, the original *La Clinica* is gone, and the government has set up a new facility with a full-time physician. In general the medical situation has improved.

Sklar discovers how the narcotic *traficante* gangs have come to dominate the lives of all the people in this region of rural Mexico in the years since he left (and this dreadful situation with murder and kidnapping on an outrageous scale persists today, especially along the border):

The village and the clinic had been my engine all these years, powering me forward with a vision of why my life made sense and a certainty of its basic goodness. In the village the needs were obvious. If you worked hard enough, the dying might live, the suffering might be relieved, and you could feel good about your part in it. . . . I wanted to discover what led me to make the choices that were now causing so much pain and to determine whether my image of the village, the clinic, and the relationships with the people there was based upon real memories or fantasies. Maybe that would help me discern the next step away from the fog enveloping me.^{P4}

On several occasions Sklar reveals interactions with his long-time colleague,

Rick, a cynical racist whose deep-seated prejudices encompass ethnic and social "classes." One must wonder if his biases could jeopardize his judgment in caring for patients he considers less "worthy," and how the author could maintain friendship with such a person. It is a rather anomalous interjection for this altruistic writer.

In contemplating this rather strange book, I wondered what long-range impact the time in the village had upon his ultimate philosophy of life in medicine. He is now an associate dean at a Western medical school—far removed from the poor of rural Mexico. One can only wonder if his sensitivity to patient welfare, his concern about the prevailing health care mechanism where individuals are getting rich from the illness of others while many millions remain outside the system, plus his knowledge of Third World medical problems, has been translated into any continuing positive action. There is no indication in the book.

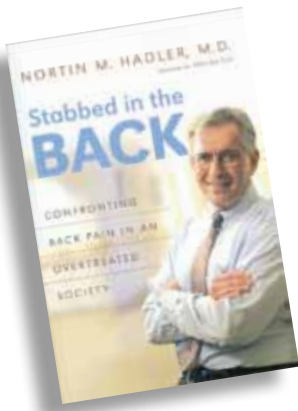
In the final pages Sklar contemplates the legacy of Carl Wilson:

I wondered what his legacy would be, how we would remember him. Would it be the images of the clinic, the many people from the village whose lives had been changed, the Americans like me who returned to the United States to try to carry forward the same compassion and commitment to the poor that we learned from him? Or would it be the scandal?^{P233}

The prose is colorful and the narrative quite fascinating at times, but the book leaves a disquieting, unfulfilled aftertaste and ends on an inane downbeat.

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**Stabbed in the Back:
Confronting Back Pain in an
Overtreated Society**

Nortin M. Hadler
The University of North Carolina Press,
Chapel Hill, North Carolina, 2009,
224 pages

Reviewed by Paul Levin, MD

No one would choose to be in pain. Pain is, well . . . painful! People seek explanations. If something hurts, human nature tells us there must be a problem. Patients and health care providers become frustrated when they can't get an explanation. Individuals who are experiencing pain are a willing prey for anyone who offers them a solution. In many ways our present health care system has created the perfect storm: a needy and sometimes desperate patient population, interacting with a variety of health care providers who are eager to help, but who also make their livelihood providing the services they recommend.

Stabbed in the Back: Confronting Back Pain in an Overtreated Society is a very sobering analysis of the American approach to the management of back pain. Nortin Hadler, MD, has spent his thirty-year professional career analyzing the evaluation and treatment of back pain in the United States. Dr. Hadler notes that essentially everyone in Western society experiences episodes of back pain. Although a wide variety of health care providers treat back pain, their commonly used diagnoses, such

as arthritis, disc disease, pinched nerve, pulled muscle, joint subluxations, and spinal malalignment fail to withstand the rigors of clinical testing. Instead, Dr. Hadler introduces the more generic term "regional back pain," thus removing any medical diagnosis when describing and explaining everyday episodes of back pain. Through his exhaustive review of the literature, he is able to support his contention that back pain is simply an unpleasant experience in life and of the human condition. It is *not* a pathologic condition requiring diagnosis and treatment. The role of the physician should simply be to "provide a port in the storm: empathy, wisdom, reassurance, and constructive advice."^{p53}

Stabbed in the Back guides the reader through the evolution of the medical profession's involvement in the care of individuals presenting with complaints of back pain. This involvement transformed people with common back pain into patients and, by necessity, changed the perception of their discomfort from an annoyance of life to a pathologic condition. Adhering to Sydenham's principal that symptoms (illness) must represent anatomic or physiologic malfunction (disease), physicians rushed to identify pathologies that "fit" their conceptual frameworks. Allopaths, osteopaths, and chiropractors, among others, have developed their own explanations and theories of the pathologic processes that lead to back pain. Even more disturbing, health care professionals have helped create disability in patients diagnosed with a "disease" for which the "cure is elusive"^{p29} and many of whom "see no better option than to be patients for predicaments they perceive to be abnormal but that others consider normal."^{p29}

Simultaneously, while the medical profession was pursuing and analyzing the etiology of back pain, the Workman's Compensation system was created. This system requires that any worker reporting symptoms of back pain must demonstrate injury. If no injury can be demonstrated, workers are neither eligible for compensated treatment nor

for financial settlement. The conjunction of Workman's Compensation with the medicalization of back pain has created a snowballing phenomenon of abuse and led many people, who might otherwise accept their symptomatology and move forward in their lives, to label themselves as permanently disabled. These combined forces have created a "Back Pain Industry" in which billions of health care dollars are wasted.

Dr. Hadler supports his arguments with voluminous references. No intervention has been shown to have any long-term benefit in the care of people with regional back pain. The care of these individuals has become very provincial, with each specialty organization (spine surgeons, physical medicine and rehabilitation specialists, chiropractors, physical therapists) all aggressively lobbying for insurance reimbursement for their modalities and resisting any attempt by the government to establish "best practice guidelines" or evidence-based management.

I do have a single criticism of Dr. Hadler's treatise. Chapter Six, "Invasion of the Spine Surgeons," extensively outlines a history of abuse of surgical interventions for regional back pain. Undoubtedly, a large volume of spine surgery is being performed without any scientific basis. Despite the excesses, I am concerned that the reader might be left with the belief that there are, in fact, *no* indications for spine surgery. However, while patients with regional back pain are best treated with education and reassurance, a very small percentage of individuals with back pain do have conditions for which operative intervention is appropriate. Much of the confusion lies with the lax use of terminology. For example, disc herniation becomes significant only when it results in radiculopathy or acute neurologic deficit. Spinal stenosis is an imaging finding that is only significant if it leads to neurogenic claudication. Simple lumbar discectomy performed for a true radiculopathy (not a generalized radiating pain, or a herniated disc without radiculopathy) has been demonstrated to

have an extremely high success rate. The SPORT trial (Spine Patients Research Outcomes Trial), although partially flawed with crossover patients, and the Leiden-The Hague Spine Intervention Prognostic Study Group have demonstrated a definite benefit with lumbar discectomy in appropriately selected patients.^{1,2}

Likewise, decompression surgery for patients with true neurogenic claudication (not simple spinal stenosis) can be extremely effective in restoring function, and decompression surgery for individuals with cervical myelopathy can restore function and prevent deterioration. It is incumbent upon the health provider to develop the appropriate clinical skills to identify this select population that could possibly benefit from a surgical intervention after failure

to respond to observation and expectant patience.

Stabbed in the Back is a superb analysis of the treatment of back pain in the United States. Beyond that, it is an eye-opening synopsis of the American health care system and how we approach our patients' complaints. It stimulates us to analyze and question commonly-accepted treatments utilized in the management of self-limiting conditions for which patients consult us. We need to consider carefully whether we are treating disease or, alternatively, creating disease and disability. This book should be required reading for any health care provider treating back pain. In fact, this should be required reading for all health care providers, regardless of their areas of expertise!

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Letters to the editor

Re “Cost of a Life”

I am writing a note in response to the article on Health Policy in the Autumn 2010 issue of *The Pharos* (pp. 32–33), written by Benson Shih-Han Hsu, MD.

I think the essay was extremely timely and a topic that needs to be discussed considerably more by physicians and perhaps somewhat less by politicians. However, I do take issue with Dr. Hsu's ultimate conclusion. He states that resources spent or not spent on JR's care have little or no immediate impact on the care of others. Unfortunately, I think that is not precisely accurate. When such extraordinary expenses are paid on behalf of one individual, it raises the overall cost of health care and the cost of insurance. As the cost of health insurance rises, fewer and fewer people are insured. Businesses and institutions opt to drop insurance for their employees and we have a higher proportion of uninsured. Therefore,

more people are not getting the basic care required.

While I may agree that limiting care may not ethically make any sense, I do think economically it does have an impact and has to be discussed. As physicians we certainly share in the responsibility of the cost of medical care.

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Au contraire: Response to “Neither/Nor”

Dr. Miles Otto Foltermann's lengthy letter entitled “Neither/nor” in the Autumn 2010 issue of *The Pharos* (p. 43) utilizes the extraction of quotes, out of context, and inaccuracies in the condemnation of an entity, i.e., existentialism.

Jean Paul Sartre's treatise *Existentialisme est un humanisme* is properly translated *Existentialism is a Humanism* not as *Existentialism and Humanism* as Dr. Foltermann purports.

“Humanism,” defined by Dictionary.com, is a mode of thought in which human interests, values, and dignity predominate. Enough said re Sartre.

While one may not agree with its tenets, existentialism is considered a philosophy and taught in the philosophy departments at most major universities. It is not an “anti-philosophy.” Few comments could be more subjective.

Existentialism, in philosophy lingo, is described as being opposed to two more traditional branches, those of rationalism and empiricism. To turn around and therefore say existentialism is “irrationalism” shows ignorance. Such a statement is ludicrous.

Ultimately, to have experienced and witnessed humanistic despair, as is present throughout our world, cannot help but make us better physicians. “To practice medicine independent of this philosophy” is a terrible mistake.

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