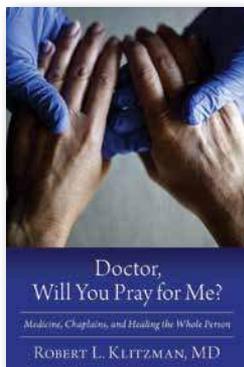


# Book reviews

Jack Coulehan, MD, MPH, Book Review Editor



## **Doctor, Will You Pray for Me? Medicine, Chaplains, and Healing the Whole Person**

Robert L. Klitzman, MD  
Oxford University Press  
2024, 328 pages

**Reviewed by John Peteet, MD  
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Robert Klitzman, a professor of psychiatry at Columbia University, lost his sister, Karen, in the World Trade Center attack on 9/11, an experience that made him acutely aware of the existential and spiritual questions that patients and their families commonly face. His subsequent interviews with physicians, who had themselves become patients, encouraged him to better understand the role of hospital chaplains. Often chaplains can deal with those issues that physicians generally lack the time or are too uncomfortable to discuss.

Much of the book's content is based on confidential, in-depth, semi-structured interviews, the findings of which have been published in scholarly journals. The author's engaging, readable style makes the book accessible to a general audience, as Klitzman draws on his clinical and personal experience, the scholarly literature, and vignettes described in participants' own words. Klitzman identifies a number of factors that contribute to the neglect of spiritual care: physicians' preferences for science and cure over consolation, their discomfort with their own uncertainties, their lack of training in responding to patients' concerns, and their limited knowledge of what chaplains do.

Chaplains come from a wide range of backgrounds and have various influences that motivate them to enter the service. They tend to be sensitive to the fears of patients and their families. Chaplains offer such individuals a non-denominational presence, open-ended inquiry, and active listening to help them make sense of their suffering and find the strength to go on. In doing so, chaplains draw on personal as well as professional experience. For example, they attend to language and silence, identify patients' priorities and struggles, and

consider potentially valuable resources to suggest for further support.

Patients who are religious, who may feel let down, punished by or angry at their God owing to illness, can benefit from revisiting the teachings of their tradition. Patients who are spiritual, but not religious, who may be inspired by nature, science, or a moral tradition of some sort, can find meaning in and hope from establishing a connection with a larger reality, however they define it, especially those who are facing the threat of death. Atheists and agnostics, who may ordinarily reject a visit from a spiritual-care provider, can recognize in a chaplain someone who is willing to meet them where they are, regardless of their beliefs (or lack thereof). In short, patients of all kinds can draw on their conversations with a chaplain to revisit or reevaluate their priorities and better appreciate the present.

Chaplains can serve not only patients, but the people surrounding them, in many other capacities. Along with guiding patients in reassessing miracles and false hopes, chaplains can facilitate such practices as ritual or prayer (used by agnostics as well as believers). They can also advocate for nonverbal, mentally ill, minority, or LGBTQ+ patients. Moreover, chaplains can support any family or medical team members who may be dealing with grief and loss. Chaplains can, likewise, model and coach ways to converse on existential topics, and aid everyone involved in end-of-life decision-making. Chaplains, given their openness, imagination, and relative lack of time constraints, can even help hospital staff understand the stories of stigmatized patients, while helping vulnerable patients navigate the hospital system.

Chaplains nonetheless confront significant challenges. Perhaps the greatest among these is maintaining their professional distance. Chaplains must manage their own emotional responses; indeed, they must stay calm and composed even as they balance competing goals, form and end relationships with successive patients, and deal with misunderstanding from physicians and other hospital staff—not to mention the outright rejection that chaplains must cope with from some patients and family members. Chaplains are also subject to underfunding and budget cuts. They can reduce these challenges to a degree by systematizing assessments and publishing research.

Physicians can help as well by learning from chaplains how to talk meaningfully with patients about what matters most to them. Together, chaplains and physicians can foster mutual learning through rounds, coursework, and collaboration around shared cases. Unsurprisingly, two especially absorbing chapters of Klitzman's book are the following: "Doctor, do you believe in God?: Physicians facing religious and spiritual questions," and "When doctors cry: Assisting staff with stress." The human, professional, and cultural facets of physicians' own difficulty with spiritual issues have practical implications for physicians themselves and their patients.

This thoughtful and sympathetic exploration of existential/spiritual care is timely. An increasingly corporate and technical medical culture threatens to eclipse the consideration of the patient as a whole person. While the growth of palliative care has called attention to the needs of patients with serious illness for spiritual care,<sup>1</sup> the majority of medical schools and residencies lack formal education in this area. And as patient populations become more culturally and spiritually diverse, they become more challenging to support through traditional institutional practices.

How does a deeper understanding of the work of chaplains contribute to better care for the whole patient? It can assist clinicians in learning how to better recognize and respond to patients' existential and spiritual concerns, and to partner with chaplains in teaching those skills to trainees. It can help the medical profession better define and assess basic competencies for spiritual first-aid provision, whether through referral or direct care. Additionally, it may encourage research into new, collaborative, cost-effective models, and establish accepted standards for staffing hospitals with spiritual-care providers.

*Doctor, Will You Pray for Me? Medicine, Chaplains, and Healing the Whole Person* is a valuable contribution that deserves to be read widely by clinicians, hospital administrators, and anyone else interested in envisioning and achieving comprehensive care.

#### References

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#### Rethinking Medications

Jerry Avorn, MD  
Simon & Schuster,  
2025, 512 pages

Reviewed by Jack Coulehan,  
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In 2021, the Food and Drug Administration gave its approval to Aduhelm, a new drug for Alzheimer's disease that didn't work, could cause brain damage, and was poised to cost the nation each year a sum the size of NASA's annual budget. How did the world's once best prescription drug regulatory body fall so low?

—Jerry Avorn

It is puzzling indeed how the Food and Drug Administration (FDA) could not only approve Aduhelm, but do so over the almost unanimous vote of its scientific advisory panel to reject approval. How could that happen? In *Rethinking Medications*, Jerry Avorn, the founder and director of Harvard's Division of Pharmacoepidemiology and Pharmacoeconomics, answers the questions raised by this shocking passage introducing Chapter 1. Avorn argues that the 2021 approval of Aduhelm resulted from a long-standing decline in the FDA's regulatory standards, a slippery slope greased by social, political, and especially pharmaceutical-industry pressures. The first half of *Rethinking Medications* is devoted to addressing three core inquiries: Does a drug work? Is it safe? And what should it cost? The second half deals with communication, patient empowerment through education, and accounts of the FDA decisions in two controversial cases, Oxycontin and the psychedelic MDMA (ecstasy).

The FDA became responsible for ensuring medication effectiveness with the 1962 passage of the

Kefauver-Harris Amendments to the Federal Food, Drug, and Cosmetic Act. Evidence of effectiveness from randomized double-blind clinical trials became a standard requirement for approval. However, during the 1980s AIDS epidemic, the FDA initiated an accelerated, or “fast track,” review process in response to social and political pressure to discover treatment for that devastating disease. Initially, fast-track approval still required evidence of clinical effectiveness or improvement, albeit with greater FDA monitoring and quicker action. Nonetheless, not long afterward, the FDA no longer required clinical evidence to approve drugs for chronic, progressive diseases, provided that those drugs significantly reduced “surrogate markers” (i.e., biochemical or pathological findings associated with the disease). For example, in the case of medications for Alzheimer’s disease, the FDA considered a significantly reduced number of amyloid plaques sufficient to approve Aduhelm, even though clinical studies had yet to document that it reduced either symptoms or declines in functioning.

The presumed fail-safe mechanism for drugs approved through the accelerated process is the requirement of confirmatory studies showing their clinical effectiveness, studies which the pharmaceutical company must complete within a set period of years. By 2022, more than half of new drug applications fell under this category of expedited review, over 80 percent of which were ultimately approved. According to Avorn, the FDA’s increasing use of surrogate markers as endpoints in trials submitted for approval amounts, in effect, to telling pharmaceutical companies, “You can market your drug if it makes a lab test look better in a short study, compared to a placebo. We won’t be on your case too much about those confirmatory follow-up studies.”<sup>p37</sup> However, ‘won’t be on your case too much’ is an overstatement. The FDA withdrew Aduhelm’s approval in 2024 when a confirmatory study showed no clinical benefit.

Part 2 of *Rethinking Medications* addresses the question, “Is a drug safe?” Applying the Hippocratic dictum, “Do no harm,” the FDA must ensure that a drug is safe even before assessing its relative risks and benefits, which, in turn, obliges the FDA to recognize any serious side effects as quickly as possible. For pharmaceutical companies, in contrast, the profit motive, at least occasionally, can outweigh the evidence of a drug’s harm. Avorn discusses in detail the case of the COX-2 inhibitor Vioxx (Merck Pharmaceuticals,

1998). Compared to other NSAIDs, Vioxx had fewer gastrointestinal (GI)-bleeding side effects for patients, while also, according to several studies, almost doubling the number of patients who experienced heart attacks and strokes. Merck nonetheless disputed this evidence for years before voluntarily removing Vioxx from the market in 2004.

Largely as a result of the Vioxx scandal, Congress passed the FDA Amendments Act in 2007, which introduced new safeguards for ensuring drug safety. These included, (a) creating a nationwide system for monitoring adverse side effects, (b) preventing companies from hiding trial results by requiring a federal registry for all clinical trials, and (c) insisting that companies complete follow-up studies after the approval of any drug.

Part 3 of *Rethinking Medications* turns to the question, “What should a drug cost?” Innovations that lead to a breakthrough medication generally derive from basic scientific research, and clinical trials, performed by university faculty and funded by the National Institutes of Health (NIH). Although the Bayh-Dole Act (1980) allows a university to patent the research behind a promising new drug, only pharmaceutical companies can develop and market the drug commercially. A university and the scientists associated with it may sell the patent in question, but the pharmaceutical company then gains control over any medication resulting from the underlying research.

While pharmaceutical companies do invest substantially in bringing some new products to market on their own, without relying on university-patented or publicly funded research, the cost of that research and development comes nowhere close to justifying the high prices that they tend to charge to customers in the United States after FDA approval. Retail prices for the same drugs in Canada, Europe, Australia, and Japan average about 60 percent less. “The largest engine driving the nation’s prodigious ability to bring new drugs to market is the hundreds of billions of taxpayer generated dollars in the National Institutes of Health,”<sup>p197</sup> and other public and private sources. The real reason that pharmaceutical companies set those prices so high is simply because they can. Most other countries have mechanisms to control drug prices based on a realistic cost/benefit analysis.

Avorn ends the book with two recent stories in the headlines, one about an FDA failure, the other about a success. The first relates to the oxycontin scandal, about which a presidential commission in

2017 found, “the FDA’s mishandling of the evaluation, approval, and use [of the drug] was an important cause of the nation’s opioid crisis.”<sup>p393</sup> The second relates to the FDA review of ecstasy (MDMA, or Methylenedioxyamphetamine), for which the advisory committee voted 10–1 against approving for the treatment of post-traumatic stress syndrome (PTSD) in 2024. In the years preceding this vote, professional and public media had widely heralded MDMA as a breakthrough treatment for resistant PTSD, and clinical trials seemed to report positive findings to that effect. Yet further analysis revealed that the investigators had failed to report adverse outcomes from the drug and exaggerated the findings of clinical improvement.

Overall, *Rethinking Medications* is a compelling read. Mistakes, scandals, and conspiracies are bound to stir intrigue, even though, to be fair, many failures of the FDA appear to stem from conflicting interests. These include reasonable responsiveness to the need for new therapies in treating degenerative diseases (surrogate markers), combined with inadequate resources and personnel to ensure that pharmaceutical companies actually conduct confirmatory studies. At times, however,

the problems of the FDA result from the pharmaceutical companies themselves in withholding critical data. The 2007 FDA Amendments Act corrected at least some of these problems, although the fate of the FDA under the Trump administration remains to be seen. With regard to the rampant profiteering of the pharmaceutical industry, there appears to be no solution in sight.

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