

Book Reviews

Myth Busters: Why Health Reform Always Goes Awry by Greg Scandlen, paperback, 158 pp, \$14.97, Kindle, \$7.97, ISBN-13: 978-1544028170, self-published through CreateSpace Independent Publishing Platform, 2017.

In spite of (or perhaps largely because of) beginning his career in health policy as a community organizer, author Greg Scandlen has had nearly 40 years of experience from several different angles. This book, taking its title somewhat tongue in cheek from the hit television series, does indeed “bust” multiple health policy myths.

Since most of the policy fallacies and failures stem largely from a single “myth,” he starts out his 30 “Episodes” explaining the false Roemer’s Law: “A built bed is a filled bed.” As I read on, trying to wrap my mind around this seemingly simple concept based on a 1959 study done by Milton Roemer, M.D., correlating the number of hospital beds and length of stay per person, I couldn’t help but hear a whispered voice say, “If you build it, they will come.” Scandlen demonstrates convincingly that this “law” is, in the author’s words, “both verifiably untrue and illogical.”

Yet this “law” essentially created health policy in this country since that time. Everything from certificate-of-need (CON) regulations to HMOs (health maintenance organizations—the grandparent of our present day Accountable Care Organizations) are based on this so-called “law.” The three pages of the first episode set the tone for the remaining 29, wherein Scandlen often reminds us of Roemer’s Law.

After uncovering untruths of such weighty topics as Hospital Rate Setting, Risk Pooling, and Universal Health Care, there is an “Interlude” (a hint of a likely musician in our author), titled “What Have We Learned So Far?” This re-cap is important to prepare us for better understanding what comes next and guides the reader to realize that our current health policy laws are nothing but a huge compilation of all the failed

policies of the past, neatly re-packaged and renamed. The reader learns that the Affordable Care Act’s (ACA’s) individual mandate requirement to buy insurance, for instance, has been around since 1991—proposed by federal Republicans and supported by none other than the Heritage Foundation. The author states that the amount of required regulation for such a mandate would “virtually eliminate choice.” He states:

Once the government mandates coverage, it has to define what benefits will fulfill the mandate, then it has to subsidize the people who cannot afford to comply, then it has to raise taxes to pay for the subsidy, then it has to control the insurance companies to make sure they aren’t overcharging for the mandated coverage. All of these steps would come true with a vengeance twenty-five years later with the enactment of the Affordable Care Act.

Because I’d been sold the lie about the huge problem of the uninsured, which was a large part of my prospective market when I started my own practice, I read with great interest “Myth Busters #9: Hysteria over the Uninsured.” Apparently, the rate of the uninsured population in the U.S. is one of the most stable statistics we have—it tends to hover at or near 20 percent over time. The reason for this stability actually lies in the fact of, ironically, the fluidity of the American populace. The idea that the number is stable because it tends to be the same folks who are uninsured over that same period of time is a falsehood. Scandlen explains:

Americans change jobs all the time. They have part-time jobs, they are independent contractors, they work on commissions, they will take on several jobs at the same time, they supplement their income by selling Avon or restoring houses in their spare time, they move from town to town and state to state, they will take six months off between

jobs to go to school or travel to Europe, they live off their savings, or sponge off girlfriends and boyfriends, they engage in barter, they win lawsuits or a lottery, they receive a substantial inheritance. To the extent health insurance is job-based, it will always be “unstable.” It will come and go along with the jobs.

On page 121 is “Myth Busters #25: Population Health,” a term that any Hippocratic physician should find disturbing. Nicely, the author uses the word “creepy” in this segment, which puts it mildly. Part of the problem with this concept is that no genuine definition exists for the term, which is definitely “creepy” because without definition it can mean anything, and, well, everything. “Clearly,” states Scandlen, “these people [those who study and support Population Health] are bored with the idea of treating one patient at a time,” which, of course is the basis of Hippocratic ethics: to stay as close to the data before the physician and therefore see each patient with “particularity.”

Most concerning to non-physician Scandlen is that the concept of population health leaves the individual patient in the background. He states, “Even more chilling is the realization that in dealing with the health of a ‘population,’ the needs of any individual are simply unimportant.”

While the book is no scholarly text, it follows the author’s purpose neatly, is very readable, and takes on the major health policies of the 20th century and of our nation today, illustrating why they are failures. He reserves his final teaching to “The Illusion of Mandatory Coverage,” and concludes with this regarding ACA: “Their compassion seems to extend only to less than a third of the 16% of the population without insurance coverage—i.e., about five percent of the American population. So 95% of the country is being put through the wringer to benefit the 5% this law was written for.”

After turning past that depressing point, the reader will be refreshed to know that the author then gives some

very educated suggestions for future policy, not leaving us without hope. He kindly suggests that it is up to us, the patients, the ultimate consumers of medical services. He reminds us that those who control the money control what it pays for.

He concludes by saying that using our consumer power "is the only way we will ever succeed in making health care more affordable, more convenient, more accountable, far less bureaucratic, and of better quality. Just like everything else in America."

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The Truth About Drug Companies: How They Deceive Us and What to Do About It, by Marcia Angell, M.D., softcover, 319 pp, \$10.11, ISBN 978-0375760945, Random House, 2005.

As Col. Nicholson staggers and falls on the detonator, blowing up the railway bridge in David Lean's 1957 war epic *The Bridge on the River Kwai*, Major Clipton, the POW camp physician, utters the film's final words: "Madness! Madness!"

Before reading this book about one of the most sinister subjects of the 20th century, written by one of such high stature within the system, I wondered why the cataclysmic world event that one would expect from such an insider exposé did not happen. It didn't take long to understand that Dr. Angell is very sympathetic to allopathic medicine and to the maintenance of the science industry necessary to perpetuate it.

As if assigned to give a report to the board of directors of "Big Pharma," and to be forthright, honest, even brutal if necessary, so the board could learn what to do to salvage the company, Dr. Angell's research points fingers at every flaw. Her research, data, and interweaving serious areas of concern expose the prescription drug industry for all to see.

To the typical utopian mindset, there is always a better way to fix a system that is not performing as desired. Something must be changed, and something will be found to keep from making similar errors that will collapse the system. There is a final appeal to the reader to go vote for the changes needed, since the public portion of the public-private partnership must be perceived to be accountable to the people. Make a better FDA! Enforce patent laws! Expose the profits and

expose how "Big Pharma" spends its money!

Standard Oil founder, "robber baron" and philanthropist John D. Rockefeller, Sr., would surely endorse an effort to whitewash a system so as to keep it running. The company cannot fail; there's too much at stake. The legal drug industry is losing its popularity in the one area that could kill it: the marketplace. People are turning away from prescription medications that are harmful and of dubious value, and certainly not of the value the corporations ask the public to pay out of pocket.

I saw that I did not need to worry about Dr. Angell's professional survival. She apparently does want the drug industry to survive, and she believes government has the answers.

The book carefully exposes corruption, and names drugs shown to be fraudulent and dangerous to the public. Yet I find it of little use on how to solve serious cultural issues, such as the hijacking of science per se. Where is the call for our medical schools to inculcate a broad understanding of pharmacology commensurate with a doctorate degree, instead of acceptance of Big Pharma's "practice guidelines"? Are there no natural remedies? Is there not a wealth of information about the biological activity of compounds in plants, including foods and herbs? Wouldn't it be nice to know more than your patients when they ask about some herbal remedy?

Isn't it time we reevaluate the command-and-control economy of the legal drug industry? Not to do so is madness. Madness!

If you want to spend a few bucks to have a book on your shelf that catalogs details of the pharmaceutical industry's deceptions, grab a copy of the book. It won't help you become a better physician, but it may suggest a reason to explore means outside the realm of the drug monopoly.

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Catastrophic Care: How American Health Care Killed My Father—and How We Can Fix It, by David Goldhill, hardcover, 369 pp, \$25.95, ISBN 978-0-307-96154-9, New York, N.Y., Alfred A. Knopf, 2013.

The key conclusion from this book was quoted by Brian Blasé in "Getting

Better Healthcare for Much Less Money," in *Forbes*, Nov. 6, 2016:

The most important single step we can take toward truly reforming our system is to move away from comprehensive health insurance as the single model for financing care. And a guiding principle of any reform should be to put the consumer, not the insurer or the government, at the center of the system....

A more consumer-centered health-care system would not rely on a single form of financing for health-care purchases; it would make use of different source of financing for different elements of care—with routine care funded largely out of our incomes; major, predictable expenses (including much end-of-life care) funded by savings and credit; and massive, unpredictable expenses funded by insurance.

There are dozens of books out there by authors all along the political spectrum with plans to fix American medicine. Unlike most of them, this one is well worth the time spent reading it, even 4 years after its publication. Its insights are certainly validated by the results we've seen with the Affordable Care Act (ACA).

David Goldhill is a liberal Democrat, and he is not a health policy expert. He is a very successful businessman, the president and chief executive officer of GSN, which operates a U.S. cable television network and is one of the world's largest digital games companies. He is also a member of the board of directors of The Leapfrog Group, an employer-sponsored organization that rates hospitals for safety and transparency. Leapfrog was funded by the Robert Wood Johnson Foundation and is very interested in Pay for Performance (P4P).

The impetus for writing the book was the death of the author's father at age 83 in a highly regarded New York hospital, after a very difficult hospital course. The story was originally published in *The Atlantic* in 2009.

Goldhill says bluntly that "American healthcare killed my father." Goldhill's observations will not be new to most AAPS members.

Healthcare is indeed different from other industries, Goldhill writes, but primarily because we insist on treating it as different. It is on an Island apart from the Mainland, with the "Surrogates"

(private insurers, Medicare, and Medicaid) having taken over the role of consumers because of the pervasive and perverse incentives of comprehensive insurance. The ACA, he writes, is “less a reform of our healthcare system than an extension of its current principles to their logical end.”

Chapter 1 is about “Island-speak,” the source of “11 strange things we all believe about healthcare.” He writes that we constantly talk about cost instead of price. He points out that healthcare isn’t health; health insurance isn’t healthcare; health insurance isn’t really insurance; technology is not really the “inflator”; and “nonprofit” hospitals really operate the same way as for-profit hospitals and often compete with them.

Politicians talk about “affordable” care while at the same time embracing provisions that are certain to drive up prices. Most people have no idea how much of their earnings is taken to cover healthcare. Goldhill adds these up for a typical employee named “Becky.” Over her lifetime, including Medicare taxes, Becky will contribute \$1.9 million to the healthcare system.

Goldhill recognizes that ACA policy is based on “a fantasy that preventive care somehow saves the healthcare system money.” He debunks the notion that we can save the system by somehow freeing up the 30 percent that is allegedly spent on excess care or waste. There is a lot of disagreement about what constitutes waste, and even getting rid of that would do nothing about the perverse economic incentives that permeate the system.

Goldhill takes the bold step of actually criticizing Medicare. The percentage of the average senior’s income spent on healthcare is now almost 50 percent higher than it was before Medicare. While seniors use a lot more medical care—the number of annual visits to a physician, clinic, or hospital per person increased by 30 percent between 1995 and 2008, there is little evidence that the improvement in seniors’ quality of life can be attributed to all that medical care. Unfortunately, Goldhill accepts the widely held myth that the administration of Medicare is very much cheaper than private insurance. But he recognizes that “even a cursory look at the finances makes it clear that Medicare is already doomed.” And no, the problem can’t be solved by spending less on “end-of-life” care.

Goldhill writes: “If you had told the seniors of 1965 that they would be getting far more treatment but that much of it

would be excessive and dangerous, and that they would be paying a far smaller share of the cost of that treatment, but that their share would still cost them more of their income, would Medicare have been enacted in the first place?”

The bill for Goldhill’s father’s hospital stay—more than \$635,000—illustrates how absurd hospital prices are compared with normal prices. Had he booked his dad a room at the most expensive hotel in town for five weeks, filled the room with a million dollars’ worth of hospital equipment leased at \$15,000 a month, given him round-the-clock nursing care, and paid a physician to spend one hour a day with him (roughly 50 minutes more than at the hospital), it would have cost about \$150,000.

Proponents of a “single payer” system, often called “Medicare for all,” argue that having a single powerful customer would have the benefit of maximum competition among suppliers and massive leverage needed to drive down prices. Goldhill explains that all-powerful customers are in many ways weaker than consumers in normal markets. For example, “Being the only customer, the government is in effect the partner of [the defense industry’s] vendors—their survival is essential.”

Many assert that countries with more socialism in their medical systems get far better value for money than the U.S. But as Goldhill points out, Americans fund only 11 percent of total spending out of pocket—among the lowest percentages in the developed world.

While many are claiming that loss of coverage if ACA is repealed will kill people, Goldhill notes that even in 45 years of an insurance-dominated health system, we don’t actually know whether having insurance saves any lives. Goldhill writes: “The ACA is just the latest in a long line of legislation that drives resources from all other goods into healthcare. To those who think healthcare should never be a matter of money, I can only ask: Can you think of any other use of \$200 billion a year that would have less of an impact on the lives, not to mention the health, of these mostly low-income Americans?”

Unlike most self-professed liberals, Goldhill is not primarily concerned with redistributing the wealth equally, but he does emphasize that the system has to work for the most vulnerable. He looks upon Singapore as the ideal example, which does have a lower tier of socialized medicine tax-funded care accessible to

all. He also understands that we cannot rebuild overnight a workable system after having 45 years of destructive policies.

After a magnificent analysis of the perverse economic incentives, Goldhill proposes his plan, called “the Balanced Health System,” consisting of health accounts, health loans, and catastrophic insurance with a very high deductible. Unfortunately, it’s still a government-dictated system with massive redistribution of wealth, using current Medicaid spending to fund accounts for Medicaid beneficiaries. At least he doesn’t count on interest income growing the health accounts, but he does not acknowledge that the government’s zero interest rate policy has really stolen interest from all American savers. He assumes the stability of the banking system and the ability of the people to insulate it from the hands of government and others who will want to plunder it, and from the inevitable moral hazards, which he does recognize very well for insurance.

It is also disturbing that Goldhill buys completely into the Institute of Medicine’s statements about how medical errors are killing so many people, and the ability of electronic health records and protocols to solve that problem. He seems unaware of the dangers as well as inefficiencies of the EHR as currently implemented. He cites the RAND assertion that universal implementation of information technology would have an 80 percent annual return on investment.

Most physicians will not be as shocked as Goldhill was at the inefficiencies and errors in his father’s treatment. But ultimately the cause of death was infection, probably with a multiple drug-resistant organism. The remedy might not be in more data-mining protocols, more checklists, and more Leapfrog scoring, but in something much simpler that he mentions very early in the book. The patient’s trash was emptied only once per day, often after it had overflowed. Maybe what we need is to prioritize basic housekeeping, and study intensely the sources and modes of transmission of infections.

Like so many other books, this one does an excellent analysis of the problem, but really falls down on trying to prescribe a comprehensive, centrally managed solution. Goldhill has far too much faith in computers and too little knowledge of the basic human activities involved in taking care of very sick patients.

I wish the book had an index. It does have good references. All in all, I highly recommend it.

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The Laws of Medicine: Field Notes from an Uncertain Science, by Siddhartha Mukherjee, M.D., Ph.D., hardcover, 96 pp, \$11.55, ISBN 1476784841, New York, N.Y., Simon & Schuster, 2015.

Dr. Mukherjee elucidates the key nuances that make medicine unique among the sciences. Starting from the principle that scientific laws become more flexible as one travels down the reductionist hierarchy (from physics to chemistry to biology), Dr. Mukherjee shows that medicine is less tame than any of its predecessors. To resolve this rift between medicine's scientific origins and its variety of surprises, he develops a set of laws in medicine that can be summarized in three words: priors, outliers, and biases.

Through a variety of medical case studies, anecdotes of nonmedical scientific discoveries, and clear explanations, Dr. Mukherjee explains that the laws of medicine are truly laws of probability, exceptionalism, and bias. On probability, using the principles of Bayesian inference, he shows the effect of false positives and why having prior knowledge before a diagnosis is important. Shifting from his probabilistic thinking on priors and probability, he focuses on outliers and how they contribute greatly to shifts in medical and scientific research. This is reminiscent of Malcolm Gladwell's book *Outliers* and his focus on developing rules through studying exceptions. Lastly, on biases in medical experimentation, Dr. Mukherjee reminds us that human biases underlie the hypotheses and execution of experiments, and that these biases must be kept in mind when trying to link the literature to a patient.

I recommend *The Laws of Medicine* for any aspiring or practicing physician, as it provides an excellent insight into the tumultuous and unpredictable world medicine encompasses. The book also serves as a reminder that no two patients or cases, like snowflakes, are alike. Differences in habits, genes, and a myriad of other factors can make every treatment or diagnosis a surprise, or an

exception to the previous patient. *The Laws of Medicine* outlines the principles that make medicine an alluring, unpredictable, and exciting field.

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Brainwashed: The Seductive Appeal of Mindless Neuroscience, by Sally Satel, M.D., and Scott Lilienfeld, Ph.D., paperback, 256 pp, \$16.97, ISBN-13: 978-0465062911, Basic Books, 2015.

Circumspection is the soul of scientific integrity. In *Brainwashed*, Sally Satel and Scott Lilienfeld expose the commercial and political influences behind the current trend in neuroscience of extrapolating far beyond the available evidence. This book addresses the misuse of neuroscience in the fields of marketing, addictions, brain-based lie detection, and the law.

The authors' central hypotheses appear to be that: (1) The ancient paradox of a mind that is constituted in a physical body is unlikely to be resolved by reducing all mental activity into its physical brain correlates. (2) The equally ancient moral problems of freedom and responsibility will not be solved by neuroscience practiced in a reductionist way. (3) There are risks in relinquishing control of any of the levers with which we can move our world, especially if we leave them in the hands of others who have no qualms about over-promising for personal gain. There are various hierarchical levels at which we can organize our experience: molecule, protein, gene, neuron, neural networks, anatomical structures, conscious mental states—thoughts and feelings, family, workplace, culture, natural environment. Different levels of explanation are more informative for some purposes than others, and we lose valuable opportunities for problem solving any time we focus on one level at the expense of all others.

Neurocentrism is the fashionable view that human experience and behavior can be best explained from the predominant or even exclusive perspective of the brain. The authors illustrate its excesses with a fine compendium of anecdotes that range from the amusing to disheartening. "Men See Bikini-Clad Women as Objects,

Psychologists Say" might just as well appear in a sidebar on your computer screen as in a scientific journal. Certain forensic experts envision a time when we will "eventually think about bad decision making in the same way we think about any physical process such as diabetes and lung diseases." Alan Leshner, past director of the National Institutes of Mental Health, shamelessly takes credit for the idea of brain disease "branding." He fondly recalled that members of the United States Congress accepted research results more readily when they were presented along with color images of the brain.

In the chapter of the book I found most useful, Satel and Lilienfeld remind us that functional MRI images are computer-generated, based on the inference that oxygen uptake correlates with increased activity in a brain region. Of all of our senses, we rely on vision the most, so it is easy to succumb to naïve realism and think that a brain scan is an actual picture of a brain.

In the matter of chemical dependency, an overly reductionist approach—"addiction is a chronic relapsing brain disease"—cancels out the role of personal responsibility in a group of patients who particularly need encouragement for personal initiative. It also overlooks key environmental factors, say the authors, that promote continued use or recovery, and that oversight could mean the loss of an important clinical lever.

In the courtroom, excessive use of a neuroscience that fails to distinguish between cause and correlation means that bad science takes the place of philosophy as the correct field of inquiry to explore the problem of moral responsibility. Satel and Lilienfeld point out that a blameless world is a cold world that lacks empathy and forgiveness.

The authors disappointed me by choosing not to tackle the hegemony of mindless neurocentrism in clinical psychiatric practice. I see my colleagues relying more and more on complex, toxic psychopharmacology cocktails, all justified by simplistic models of neurotransmitter function. Pharmaceutical-funded psychiatrist investigators never leave home without their slides of multicolored brains and synapse cartoons. It is hard to know whether third-party fee schedules that promote increasingly brief visits are

cause or effect. If over-prescribing truly needs to be reined in, then a robust debate among scientists, perhaps led by neuroscience skeptics like Satel and Lilienfeld, would be a far better approach than politically motivated, punitive law enforcement and medical board actions.

Brainwashed provides a useful review of a recent enthusiasm in our culture. Over-promising neuroscientists and their credulous audiences might all do well to remember Shakespeare's admonition by his title character in *Hamlet*: "There are more things in heaven and Earth, Horatio, than are dreamt of in your philosophy."

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Moving Mountains: A Socratic Challenge to the Theory and Practice of Population Medicine, by Michel Accad, M.D., softcover, 125 pp, \$12.99, ISBN 978-163-432-0306, College Station, Tex., Green Publishing House, 2017.

This slim volume is a takedown of the book *The Strategy of Preventive Medicine* by the late Geoffrey Rose, who is one of the intellectual founders of the population health movement. Rose had the idea of applying the techniques of preventive medicine to the whole population, rather than just to high-risk individuals.

Dr. Accad uses the device of an imaginary dialogue between Socrates and Professor Rose. The concept is aptly illustrated on the front cover: A white-coated professor is mightily trying to tug to the left a Gaussian probability distribution.

Rose had the idea that risk factors for disease followed the bell-shaped curve and that most clinical complications would occur not in the minority of people at the high-risk end, but in subjects within the center of the distribution. He also believed that the primary determinants of disease included economic and social factors. Thus, one primary goal was to eliminate "health inequities." Dr. Accad writes: "By prescribing a reduction in health inequities, Rose's theory echoes the thought of contemporary political philosophers, such as John Rawls's theory of social justice. But Rose's ideas provide social justice theories with needed scientific validation."

Rose introduces Socrates to the concept of quantitative disease continuously distributed through a population, as opposed to the dichotomous concept of one population of sick persons and one of well persons. It is noted that this might be viewed as a step backward to the ancient concept of every disease being a quantitative imbalance of various humors. Socrates points out the logical flaws as well as the fundamentally false assumption that risk factors have a symmetrical Gaussian distribution.

Socrates also points out factual assumptions that turned out to be untrue. For example, Rose's book states: "Although no one can be certain, it is widely assumed that the dose relationship between radiation exposure and cancer is threshold free and linear." What was widely assumed in 1992 is now widely challenged. But the Rose character in the dialogue says: "Socrates, let's not have paralysis by analysis!" After all, we have serious public health problems on our hands, and we should not allow chances of causing harm to prevent us from moving forward.

Socrates concludes that we should "declare peace on risk factors and let doctors treat individual patients." He tells Rose: "Your enthusiasm for shifting distribution curves must be tempered. It takes faith to move mountains, but moving statistical mountains of risk factors can cause landslides, avalanches, or earthquakes! These are people's lives you aim to manipulate!"

In an epilogue, Dr. Accad shows that evidence-based medicine, based on randomized controlled studies, is really treating a population measure instead of individual patients. This utilitarian ethics of population medicine was enshrined in the American College of Physicians updated ethics manual in 2012.

Population medicine is an instrument for an egalitarian utopia, Dr. Accad concludes: "Contrary to what it may claim then, the goal of population medicine is *equality as an end in itself*."

This book is based on commentaries previously posted on Dr. Accad's blog *AlertandOriented.com*, which is a great source of insights on medical science, medical ethics, and medical economics.

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PEOPLE ARE TALKING ABOUT MYTH BUSTERS

Linda Gorman. "Greg Scandlen provides clear, concise, common sense explanations of why generally accepted health policy ideas fail the reality test."

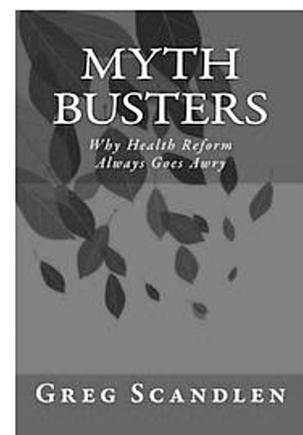
John McLaughry. "This 156 page memoir is a collection of what Greg learned over four decades from watching dumb, foolish, self-interested, and misguided efforts of various groups of policy geniuses to "reform" health policy."

Rick Willard. "Greg Scandlen has taken his rightful place as one of the incisive thought leaders in the Health Reform world. We can all learn from his experience and his practical interpretations of how we got into this mess."

Dave Racer. "Scandlen has done the heavy lifting of giving us data to expose the myths of pin-headed academics and politicians who care very little about individual patients."

Dan Perrin. "Greg's decades in health care policy come shining through in this excellent book. A must read for serious people who have a serious interest in health care policy."

Allan Wald, MD. "A magnificent presentation of the myths that have led to so many mistakes in healthcare policy. Scandlen is an insightful independent thinker and that becomes clear each time a myth is revealed. If only the people in academia could be as concise and clear. A must read for anyone that wants to understand the healthcare debate."



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