BOOK REVIEWS

What Kind of Life: The Limits of Medical Progress. BY DANIEL CALLAHAN. New York, Simon and Schuster, 1990. 318 pages; $19.95.

MANY who would stem the rising costs of health care in this country focus on supply, and attempt to control physician practices as a way to reduce total expenditures. Others focus on demand, particularly the role that insurance plays in creating a medical commons. Daniel Callahan argues that these strategies are a form of denial. The denial is embodied in the belief that some "managerial fix" can redirect our priorities away from health and toward other important social goods. The real problem, simply stated, is that Americans want more health care than they ought to want.

This is a problem of human values. Since death is inevitable, no matter what the advances of medical science, we ought to recognize our ever-expanding need for health care as a sign that the quest is futile. Callahan argues that we must resist the belief that our economic salvation rests with a medical advance just around the corner. The successes of medicine, not its failures, are the root of our troubles. We have been teased by these successes to move ever forward, like the mule chasing the carrot always beyond its reach. In turn, we have inflated individual values and expectations until we no longer recognize health as a means to a good life, but as an end in itself.

Callahan believes this is why Americans want more health care than they ought to want. He allows this distinction by stressing the value of societal goals over individual goals. In doing so, Callahan intertwines two themes. The first theme is economic: as a society, we must learn to eliminate not only those technologies that are ineffective or marginally effective, but also those technologies that while effective are simply unaffordable. Americans have too rich a diet of health care, but it is yet another form of denial to believe that trimming the fat alone will be enough.

Knowing where to cut is the second theme. We must be willing to apply strict standards based on a substantive view of human well-being. The standards Callahan proposes recognize human beings less as individuals and more as members of a society. The appropriate standards should be at once rich enough to maintain important societal institutions and modest enough to leave money on the table for other social needs. The kind of medicine that is forever expanding its frontiers may be valued by particular individuals, but it is not a societal need. We should shift away from this pursuit of curative medicine — medicine that would strive to conquer disease — and adopt instead a strategy of caring for patients through their suffering. Universal caring for suffering patients represents a minimum standard a good society requires in order to function. "I can understand why someone would want to live to 105, but it is not evident that I am required, as his fellow citizen and fellow human being, to contribute support toward helping him achieve through expensive means that highly individualized goal."

How should we reconcile Callahan's two intertwined themes? If he really means to use standards of cost-effectiveness to set limits, what if a system of universal entitlement to caring were as prohibitively expensive as a system devoted to curing? Even if it were cheaper at the start, and we could get there from here, how could we keep the ever-rising expectations of individuals from shifting societal "needs" upward? His willingness to allow a minimum standard of health care, supported by and for the society, alongside a richer standard, supported by and for individuals who could afford it, virtually guarantees these inflationary expectations.

It is at times difficult to follow Callahan's argument supporting this priority of societal over individual goals, or his belief that it could be maintained. And it is easy to be pessimistic about change in the first place when, by and large, medical decisions are made by individual patients and their individual physicians — both unused to recognizing the commons as a shared responsibility. But Callahan is a limit-setter courageous in his quest to restrict individual choice by imposing external constraint. The overall message of the book is compelling: it is time to begin accepting the limits of medical progress and start setting some limits ourselves. Some of these limits will be arbitrary, but to refuse to set them for that reason is to deny the problem we face — DAVID A. ASCH, MD, MBA, *University of Pennsylvania School of Medicine, Philadelphia, PA*

Doctors Under Hitler. BY MICHAEL H. KATER. Chapel Hill, NC, The University of North Carolina Press, 1989. $32.50.

DOCTORS UNDER HITLER, is a study of the medical profession in Germany at the time preceding and during World War II. The main focus of the book is on the role of physicians in Nazi society, and how physicians adapted to or were part of the maladaptation of that society. Kater looks at the extent to which physicians participated in the government and the extent to which the prevailing views of the government infiltrated and undermined the lofty goals of physicianhood as set out in the Hippocratic Oath. Some physicians resisted the trend toward corruption, and they are portrayed in the book more or less as heroes.

Much is made in the book of the theories of racial supremacy, and how these ideas came to be incorporated and even to predominate in German "academic medicine." These "theories" were presented in the medical schools under the guise of science, except that, as Kater points out, the conclusions had already been reached before the "science" was undertaken.

In contrast to earlier works by or about Nazi doctors, this is not another account of the atrocities committed by German physicians in the name of science. Nor is it a psychosocial account that makes its larger points by in-depth exploration of representative physicians. Rather, this book attempts to create the climate of the time in German medicine by looking at the working conditions, incomes, and social and political roles of many groups of physicians. The book is steeped in archival references, which give it a fabric of authenticity. On the other hand, by cataloguing so much, Kater does not write what at times could have been a more revealing account of certain selected doctors.

This is a far different book from Lifton's *The Nazi Doctors*, both in scope and in presentation. Kater's book is not about Nazi doctors per se, but about doctors in general. And

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whereas Lifton uses psychological profiles to enlarge our understanding, Kater's approach is more sociological, with little more than a cursory look at underlying motivation. The overall effect is somewhat fragmented, without much of a story line. Yet the weave of the book is rich, with an undeniable authority stemming from an obvious fund of knowledge and painstaking research. And perhaps this is the most important thing in a book that investigates a topic never formally studied before.

In the second-to-last chapter, Kater addresses the issue of the persecution of Jewish physicians. This chapter is better integrated than some of the earlier chapters, perhaps because of its more narrow focus. Kater traces the gradual disenfranchisement of the Jewish physician in a convincing and factual manner, shedding quite a bit of light on a subject that has long intrigued people, namely why so many stayed as long as they did. Kater looks at the difficulties of emigration, the temporary reprieves that gave people false hope, as well as the stubborn refusal of many to give up their homes and what was familiar to them. Even though this chapter examines the disenfranchisement of the Jewish physician in particular, it has a broader application to all Jews living in Germany in the 1930s.

Doctors Under Hitler is worth a look for readers interested in World War II, especially those interested in the politics of working under Nazi rule and the perversions in medical care that Nazi doctrine necessitated. What the book sacrifices due to its complexity and fragmented approach, it makes up for by virtue of its richness. — MARC SIEGEL, MD, *New York University Medical Center. New York, NY*

Textbook of Medical Ethics. BY ERICH H. LOEWY. New York, Plenum, 1989. 252 pages, $35.00.

DR. ERICH LOEWY'S *Textbook of Medical Ethics* has as its audience physicians, and in particular medical students and housestaff, for whom this book would presumably be a primary text in a course on medical ethics. For this audience, it is very appropriate. Composed of 13 short and easily digestible chapters, suitable as assigned readings, it is clearly written, well organized, and reasonably broad in its coverage of the various important bioethical issues, and has adequate references.

While the book fails to advance a new or cohesive theory of ethical reasoning or offer fresh insight into ethical decision making in clinical settings that would distinguish it from the other members of an already crowded field of textbooks of medical ethics, it does have a decidedly clinical feel to it. This feature, combined with its readability, make it an excellent choice as an introductory primer for medical students and housestaff. For example, in chapters entitled "Problems at the Beginning of Life" and "Problems in the Care of the Terminally Ill," Dr. Loewy skillfully considers ethical problems posed by defective newborns, anencephalic organ donors, surrogacy, forced cesarean section, DNR decisions, limitation of medical treatment, and euthanasia.

The book opens with the traditional chapters on the historical underpinnings of medical ethics and the philosophical bases of ethical thinking; these two chapters are well done. One of the strengths of this book is the way that topics that are ordinarily considered separately are synthesized. For example, the topics of consent, confidentiality, and human experimentation are all considered under the rubric of the doctor–patient relationship. The book also has three chapters that are relatively unusual, on risk taking, the problem of blameworthiness, and the physician as citizen. It concludes with a chapter that contains 16 cases with accompanying analyses. The cases have a very real and very clinical feel to them. It is gratifying that two of them, with which the author was apparently especially familiar, are accompanied by an addendum that shares the outcomes of the original cases with the reader. One of the cases (case 10) is quite novel. It appropriately extends the domain of medical ethics into the administrative decisions made in hospitals about what type of services to offer the community. None of the cases deals with the conduct of biomedical research with humans.

The book is tantalizing in the way it commendably considers two issues in contemporary medical ethics that I consider to be of utmost theoretical and practical significance. Unfortunately, the author abandons them after only superficial treatment. The two issues are 1) the role of culture in shaping ethical rules and ethical decisions, and 2) the role of suffering in medical ethics.

The role of sociocultural factors in shaping ethical values and ethical decision making has only recently been seriously studied. It is clear that "medical ethics," as they are traditionally configured, are *Western* medical ethics and are very much the product of our own historical and cultural background (some points of which Dr. Loewy reviews). Dr. Loewy remarks that

> if health and disease are, in fact, social constructs, and if what we consider to be a "healer" is conditioned by societal viewpoints of health and disease, then the physician–patient relationship is also very much molded by the society in which it occurs. . . . In consequence, the physician–patient relationship will be different in differing cultures. Models which seem appropriate to one culture and to one historical epoch cannot simply be transplanted and be expected to flourish. (51)

Having appropriately placed medicine and medical ethics within a cultural context, the book then misses the opportunity to confront a critical issue: the resolution of intercultural ethical differences (such as might arise when investigators of one culture conduct medical research on people from another culture) and the avoidance of Western bioethical hegemony. The rich traditions of medical ethics within non-Western medicines, such as Ayurveda or traditional Chinese medicine, and the living ethics of indigenous healers throughout the developing world receive no attention in this book. Students clearly must be made aware of the fact that the Western biomedical ethic is not perforce universal, though we might wish it to be so.

Loewy alludes to a "biologically grounded ethic," based on the fact that humans have a neocortex, as a potential basis for a universal ethic.

> This, then, is a basic norm: not to bring needless harm to another. Such a norm is rooted in the realization that man's common structure of the mind allows us all to share the ability to rejoice and to suffer. Rejoicing or suffering, in differing societies and among different individuals, may be brought about by starkly different things. But the capacity for joy and pain is a universal of sentient beings, a shared quality and value which may serve as a starting point in the quest for peaceful agreement. It is a reference point —a norm—against which to judge our actions as moral or not. (86)

Suffering warrants serious attention because it is one of the defining questions of what is at stake in human experience. There is something to the nature of bearing tribulation, something to the trials of dealing with disease, that makes suffering in the human experience a rare moral category. Suffering is an affliction of the human spirit that finds unique expression in each person and culture, and it is increasingly becoming a

focus of serious cross-cultural anthropological work. As Loewy well recognizes, suffering might indeed form a strong basis for the development of medical ethics, even if it is too primary a concept to yield many concrete ethical rules. — NICHOLAS A. CHRISTAKIS, MD, MPH, *University of Pennsylvania, Philadelphia, PA*

Heart Failure: A Critical Inquiry into American Medicine and the Revolution in Heart Care. BY THOMAS J. MOORE. New York, Random House, 1989. 308 pages; $19.95.

Heart Failure, Thomas Moore's broad attack on current medical approaches to heart disease, is the journalist's equivalent of the walk-through human heart at the natural history museum — we have the big picture for readers of all backgrounds and experience, but one that misses details and simplifies. Yet the big picture is what is often lacking when the same issues are framed solely as technical ones by physicians and policy makers. Moore challenges the "heart establishment" by translating medical controversies such as the proper role of cholesterol screening or angioplasty into moral questions of broad public concern: by whose authority was a public health compaign launched that would make patients out of a quarter of the population? Should physicians be trusted to control technologies their livelihoods depend on?

This translation is no simple task. As a journalist entering the world of cardiologists and heart surgeons, Moore feels that he has arrived "in a strange new planet where an entirely new set of rules applied." The author experiences déjà vu, recalling his entry into the twisted moral universe of the Vietnam war a generation earlier.

Moore's critique of cholesterol policy, which forms approximately a third of *Heart Failure*, appeared in the *Atlantic Monthly* in 1989 and sparked a public debate about cholesterol screening. In broad strokes, Moore argues that the epidemiologic studies that pointed to the increased risk for heart disease from high serum cholesterol are at best suggestive and do not by themselves justify a campaign to lower serum cholesterol. Big, expensive clinical trials failed to prove that medical and dietary interventions reduce mortality and serious morbidity (from all causes). The data from these trials have been selectively interpreted and reported by physicians, researchers, policy makers, and representatives of drug companies, who undemocratically launched a campaign that "determines that millions of Americans without symptoms are at risk and require expensive medical treatment."

In response to Moore's critique, the *New York Times* published an editorial that weighed the pluses and minuses of cholesterol screening in its own characteristic authoritative voice, questioning by its entry into the debate the wisdom of letting medicine mind its own store. Shortly after Moore's piece appeared, growing public skepticism forced the American Heart Association to back off from plans to offer a seal of approval for healthy food products.

In addition to cholesterol screening, Moore takes on other controversies in heart disease, such as the proper indications for bypass operations and angioplasty, the role of coronary care units, thrombolytic therapy, CPR, bad surgeons and hospitals, outcomes measurement and quality assurance. The book suffers from trying to cover so much ground. The discussions of coronary care units and thrombolytic therapy are unfocused and superficial. Moore's analysis of clinical controversies suffers from a selective presentation of primary data and a reliance on critical assessments by insider critics. Moore's unfamiliarity with the norms of clinical investigation and interpretation leads him in one instance to interpret the use of a one-tailed, rather than a two-tailed, test for significance as something "shopped for . . . deep in the fine print of statistical theory." Moore does not appreciate or is unable to translate for the general reader the problem of type 2 error. Recent reports of positive benefit for risk reduction in the MR.FIT trial after longer follow-up contradict Moore's own analysis of this study just as they illustrate the caution needed to interpret negative results. Moore's economic analysis is often simplistic, weighing costs and immediate benefits but ignoring long-term savings from prevented heart disease. On a stylistic level, most of the chapters are introduced with a clinical vignette, a device that gets tiring.

Yet it would be a mistake for physicians to dismiss Moore's provocative critique because of these flaws. Moore gives ample evidence to support his view that something is awry in the way new medical practices are introduced and existing ones justified. Moore documents the powerful role drug companies with an economic interest in cholesterol screening played in the development of national guidelines. It might appear that medical policy makers were not biased by such pressures. For example, Merck's drug lovastatin was not recommended as first-line pharmacotherapy in the national guidelines despite the pharmaceutical giant's behind-the-scenes maneuvering. In actual practice, however, lovastatin is widely prescribed because of its efficacy and ease of use. Moore thus illustrates a general problem with practice guidelines: clinical realities are frequently idealized, obscuring the real winners and losers, costs and benefits.

Moore argues that the internal logic of cardiac practice sets no limit for new treatments or who might be treated. He paraphrases "visionaries" who foresee the day when "clearing the coronary arteries of obstructions would become a routine preventative treatment like having one's teeth cleaned." At the root of the various factors that cause and sustain an aggressive, interventional, and highly technological approach to heart disease is the mindset of the individual cardiologist or heart surgeon. Moore speculates that the gradual and cumulative influence of technology on the technician leads to an overvaluation of one's own authority and the efficacy of technology. "Can a mortal human being," Moore says of heart surgeons, "cope daily with the emotional stress and technical demands of this operation without a deep and abiding conviction that this treatment has value?"

I would add to this analysis the important role language plays in sustaining these deeply held biases. Cardiologists, for example, typically argue that angioplasty has been a dramatic clinical success except for the problem of restenosis. By citing "restenosis" rather than "except they still have coronary artery disease," the problem is framed as one amenable to a technical solution just around the corner. Moore documents the many instances of subtle framing biases that lead to an overestimation of specific medical interventions, such as when cholesterol activists spoke of a 20% reduction in the relative risk of a heart attack in the treatment group of the Coronary Primary Prevention Trial to describe an absolute reduction of risk from 8% to 7%.

Moore argues that organized medicine and individual physicians abandoned their skepticism about the scientific evidence for aggressive cholesterol screening and treatment only when it became evident a national cholesterol campaign would be good for business. Moore notes, for example, that national guidelines direct physicians, who generally have been apathetic towards nutrition, to supervise dietary therapy of hypercholesterolemia. Moore is too severe in this analysis. He ignores such altruistic motives as the desire to use the immense resources of medicine to prevent, rather than merely treat, cardiovascular disease. Nor does Moore recog-

nize that making policy necessarily involves some horse trading between key players, such as making the individual doctor–patient encounter the effector arm of public health initiatives in return for clinicians' support.

As a result of these ideological and pragmatic complexities, the cholesterol controversy blurs the distinction between the traditional antagonists of health debates: advocates of prevention and lifestyle change against those who push high-tech, disease-specific remedies. The powerful role of ideology and the subordinate role of data in the cholesterol debate are illustrated by the observation that the declining cardiovascular morbidity and mortality of the last 30 years have been used by all sides of the controversy for their own purposes: by cholesterol activists to demonstrate the profound effect of changing dietary and other behaviors on disease incidence; by skeptics to argue that such changes have no correlation with decreasing mean serum cholesterol levels; and by drug companies, cardiologists, and cardiac surgeons to claim the success of specific medical and surgical innovations.

The chapters that are case studies of bad surgeons and hospitals illustrate the lack of accountability and good surveillance in medicine, but offer little analysis or generalizability. I would have liked more analysis of physicians' defensive responses to quantitative data on their own practice patterns. Moore offers many instances in which physicians argue that statistical analysis misses individual and local extenuating circumstances and other factors that form the art of clinical decision making. Sometimes physicians merely state that they, not statistics, should be trusted, e.g., the Las Vegas heart surgeon who dismissed high local operative mortality by saying, "Look, we can't all be jerks." The obvious contradiction is that while physicians often deny the significance of statistical truth when applied to their own behavior and performance, the prestige and authority of the profession rest on the objective nature of medical knowledge, which downgrades the individual case in favor of statistical truth. What lay critiques such as *Heart Failure* make clear is that the public is increasingly reluctant to let physicians have their cake and eat it too.

Moore's overall critique is too contradictory to be the basis of a comprehensive solution. While his analysis of cholesterol guidelines points to the dangers in centralized medical authority, his analysis of bad surgeons and hospitals shows the dangers of decentralized authority. Moore argues that physicians have been too skeptical about the link between low cholesterol and cancer and the efficacy of thrombolytic agents, while not skeptical enough about CABG, angioplasty, and the health benefits of lower serum cholesterol levels.

Moore concludes that what is needed is improved research in outcomes measurement and widespread adoption of quality assurance measures. Like many of the cardiac practices he critiques, such technical solutions, while needed, are unlikely to solve much unless the deeper ideological and economic forces that direct current medical practice are also changed. *Heart Failure* hints at some of these forces, but a more in-depth analysis of the history and sociology of current medical therapeutics is needed to provide a comprehensive solution for the problems Moore finds in modern medical practice. — ROBERT A. ARONOWITZ, MD, *University of Medicine and Dentistry of New Jersey/Robert Wood Johnson Medical School — Camden, NJ*

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October 1989–August 1990

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