BOOK REVIEW

Unravelling the medical-industrial complex: confessions of a reformed sinner

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Seamus O'Mahony. *Can medicine be cured? The corruption of a profession*. London: Head of Zeus Ltd, 2019. 256 pages, US$16.99. ISBN(E) 9781788544535.

Seamus O'Mahony's analysis and critique of the medical-industrial complex, including the enabling government regulatory apparatchiks and journal publishers, is relentlessly irreverent, fearlessly brazen, and all-revealing (1). Unlike other outspoken dissenters, like Nancy Olivieri (2), who, against the wishes of the corporate sponsor of a clinical trial, told the parents of a sick baby her concerns about the efficacy and toxicity of the experimental drug; David Healy (3), who exposed the risk of suicide from SSRI antidepressants; and, more recently, Peter Gotzsche (4), who touched the third rail of medicine by questioning the efficacy and safety of the HPV vaccine; O'Mahony is not likely to suffer reprisals. He is not employed by an organisation that is easily swayed by direct money considerations or the subtle puissance of external authority.

As a practising Irish physician, O'Mahony is not beholden to a university or research organisation that is subject to such influences. It would take great ingenuity and large outlays for any offended parties to reach his patients in the effort to turn them against him. Indeed, the very effort would likely provoke outrage and turn into a public relations disaster for those who might try. Heavy reliance on documented events and published statements of others offers protection—although not absolute—against slap-suit libel charges and possible payment of ruinous damages under the generous Irish libel law (5).

Richard Smith (6) characterises O'Mahony's book as the most devastating critique of modern medicine since Ivan Illich (7) in 1975 and "a strange cocktail of pleasure and despair." That we can take pleasure in the cocktail serves to remind us how ubiquitous and ingrained the corruption of medicine is—one more example of the banality of evil in everyday life. It demonstrates the extent to which doing unthinkable terrible things in an organised and systematic way has become normalised, routine, and accepted as the way things are done (8).

O'Mahony's reflections are simultaneously cognitively disruptive and enlightening. His knowledge and experience as a gastroenterologist are bolstered by a grasp of a multidisciplinary literature that extends well beyond medicine. The 14 chapters of his book are quizzically titled "People Live So Long Now," "The Greatest Breakthrough since Lunchtime," "Fifty Golden Years," "Big bad Science," "The Medical Misinformation Mess," "How to Invent a Disease," "Stop the Awareness Now," "The Never-Ending War on Cancer," "Consumerism, the NHS and the 'Mature Civilization'," "Quantified, Digitized and for Sale," "The Anti-Harlots," "The McNamara Fallacy," "The Mendacity of Empathy," and "The Mirage of Progress."

Looking at O'Mahony's book through the lens of a policy analyst and former federal and state government bureaucrat, my penchant is to focus on human and organisational behaviour and on the reliability and validity of evidence used to justify change of public policy. Individual values and preferences are seen as fundamental determinants in the social choice of public policy (9). Individual values and preferences, in turn, are heavily influenced by culture, upbringing, and experience. In this regard, I am a secular humanist of American Irish Catholic heritage who believes that science and reason make possible human perfectibility. My hierarchy of values and preferences put autonomy, fully informed consent, and patient choice of available treatment alternatives first.

O'Mahony's experience is derived largely from the UK and Ireland within an entirely state-funded National Health Service. American medicine is practised within for-profit and non-profit organisations—many with historical university or religious affiliations. Many for-profit organisations are physician-owned or have transitioned into non-profits. The American Medical Association (AMA) and individual physicians opposed passage of the 1966 Medicare Law providing universal coverage for the 65-and-older population. Students typically pursue medicine as a career to secure status, income, and wealth. Forty years later, American first-year medical students studying Spanish in Costa Rica could be encountered gratuitously raising the issue of "health care as a right" and arguing against it.

Despite these differences, there are many similarities between Irish, UK, and American medicine. O'Mahony confesses why he became a gastroenterologist and conducted largely trivial mechanistic research. Choosing gastroenterology was to

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To cite: Noble JH Jr. Unravelling the medical-industrial complex: confessions of a reformed sinner. *Indian J Med Ethics*. Published online on April 25, 2019. DOI:10.20529/IJME.2019.018.

Manuscript Editor: Sanjay A Pai

jump start his career. The more publications, the better for career success, so quick-to-finish research became the name of the game—quantity over quality. Research is the intersect where industry and government funding, government agency oversight, university and corporate research organisations, and publication empires interact and feed off one another. A machine that oils itself and grows is the conglomerate net effect. Medical researchers must publish in quantity or perish, leading to a distinctive medical school publication practice of listing many co-authors. On some American university campuses, there are snide jokes in this regard . . . "Which of the coauthors really understands the research design and statistics of the published report except the one at the very end of the list with the unpronounceable foreign name?"

O'Mahony's comparison of the rigid authority structure of medicine to that of Roman Catholic religious organisations is an apt analogy. Government, healthcare, and religious bureaucracies are all hierarchical organisations with top-down delegation of authority and control that gives leadership undue power and license to mislead and corrupt. He sees a historical parallel between contemporary biomedical science and the medieval pre-Reformation papacy:

> *Both began with high ideals. Both were taken over by careerists who corrupted these ideals, while simultaneously paying lip service to them. Both saw the trappings of worldly success as more important than the original ideal. Both created a self-serving high priesthood. The agenda for the profession is set by an academic elite (the hierarchy of bishops and cardinals), while the day-to-day work is done by low-status GPs and hospital doctors (curates, monks). This elite, despite having little to do with actual patient care, is immensely powerful in the appointment of the low-status doctors. Orthodoxy is, in part established by consensus conferences (church councils). The elite is self-serving, and recruits to its ranks people with similar values and beliefs. The elite is respected by laypeople and has the ear of politicians and princes. The elite collects research funding from laypeople and governments (tithes). This elite is rarely, if ever, challenged, claiming that its authority comes from a higher power (God/ Science). (1: p 75).*

I focus on three issues on which O'Mahony helped my understanding of how the medical-industrial complex is a threat to human progress: (a) the tyranny of authority that pervades medicine; (b) societal deference to claims of medical knowledge and capabilities; and (c) undue influence in the allocation of resources throughout the economy. His insights validate and provide broader perspective for what I have learned by study and experience during my career.

Tyranny of authority

The tyranny of authority lurks everywhere in medicine. It begins with student education and continues throughout the physician's career. The power of medical school deans to decide the success or failure of fledgling, and even established faculty members, is legendary. Its reach extends to university decisions outside the medical school relating to the acceptability of research protocols and related judgments of institutional review boards (IRBs). O'Mahony describes how medical experts use consensus conferences to amplify their authority in support of the aims of pharma, citing Petr Skrabanek's (10) account of this phenomenon in medicine as an exercise in mutual backslapping by assembled participants whose dogmatic views are well known. He mockingly characterises consensus statements as GOBSAT ('good old boys sat around a table') (1: p 113).

My first exposure to the self-serving tyranny of authority came early in my career as a federal bureaucrat, reporting to cabinet-level officials, by way of an assignment to evaluate the conduct of peer review for allocating research funds in several health, educational, and welfare agencies. There were concerns about the integrity of the process. My qualitative observations across several health and non-health agency peer review panels shaped the design of an experiment to test the effectiveness of peer review and the sources of decision-making bias (11). Peer review under strict scrutiny is effective, but unsupervised, is subject to bias. Not surprisingly, self-serving experts can and do easily help themselves out of view at government expense.

Far beyond my sliver of evidence is the reach of O'Mahony's broader account of the interactions among medical researchers, university and corporate research organisations, government agencies, and medical journal publishers that, by one estimate (12), leads to a waste of 85% of the total annual research outlays globally.

Societal deference

Society, by licensing laws and a wide range of government regulations, defers to the claims and authority of physicians to diagnose and treat the spectrum of physical and mental health conditions besetting humankind. Patient or surrogate consent is required for the physician to initiate diagnostic and treatment procedures. In the United States, laws and regulations extend the tentacles of physician authority throughout the entire health, educational, and welfare system—sometimes with, and very often without, patient or surrogate consent. The opinions of physicians are weighed in thousands if not millions of individual eligibility determinations daily—far more than those of lawyers. For services requiring direct consent as well as nonconsensual opinions, physicians receive billions of dollars annually. Thirty-seven percent of the consumer price index for medical care comprises the professional services of physicians, dentists, eye care providers, and other medical professionals (13), amounting to US$150.1 billion (4.3% of the total outlay of US$3.4921 trillion for healthcare in 2017) (14).

Americans are anointed with physician services from birth to death, requiring physician certification for Medicare and Medicaid healthcare coverage, Department of Transportation physicals and ambulance transport, social security disability benefits, state workers compensation, Family and Medical Leave Act (FMLA) permission and payment by employers,

vocational rehabilitation, special education, and services to active and retired members of the armed forces and their families. Private insurance carriers typically apply Medicare reimbursement rules for authorising payable benefits.

Americans are thus socialised and behaviourally conditioned to accept and trust the authoritative judgement of physicians throughout their lifetime. And for this reason, pharmaceutical and physical device manufacturers spend billions of dollars annually to lobby politicians for favourable policies, to pay for "Ask your doctor" advertisements in the print and electronic media, and to ply physicians with free lunches, educational freebies, and other emoluments (15–17).

Undue influence

In his chapter, "Consumerism, the NHS, and the 'Mature Civilization'," O'Mahony discusses why medical and healthcare spending decisions weigh heavily in a nation's total budget—sometimes with harmful impact on spending in other sectors of the economy. In support of his views, he cites two economist Nobel Laureates, Kenneth Arrow (18) and Paul Krugman (19), savouring and quoting at length from the latter:

> *. . . health care can't be sold like bread. It must be largely paid for by some kind of insurance. And this in turn means that someone other than the patient ends up making decisions about what to buy. Consumer choice is nonsense when it comes to health care. And you can't just trust insurance companies either—they're not in business for their health, or yours. . . . health care is complicated, and you can't rely on experience or comparison shopping. That's why doctors are supposed to follow an ethical code, why we expect more from them than from bakers or grocery store owners . . . health care just doesn't work as a standard market story (19).*

Against these atypical market forces, O'Mahony is stymied in finding a pathway to the radical reform he envisions—one that turns upside down "the current priorities of medicine—with the cathedral-like teaching hospitals and biomedical research at the top and community and hospice care at the bottom . . ." (1: p 270). He is pessimistic about societal forces that commodify all human life and give overwhelming power to giant international corporations without pushback by government regulators. He rails against "the fetishization of safety, the narcissism of the Internet and social media, but above all the spiritual dwarfism of our age, which would reduce us to digitized machines in need of constant surveillance and maintenance" (1: p 271). He asserts that the medical-industrial complex "has become so powerful . . . that medicine has now passed the Illichian tipping point where it is doing more harm than good to the people it is supposed to serve" (1: p 271). He believes it will take a cataclysmic event such as an untreatable world pandemic to bring about reform of corrupt medicine.

My personal experience as patient and as caretaker of a terminally-ill wife reinforces O'Mahony's pessimism about the extent to which industrialised medicine has depersonalised the physician-patient encounter as well as encounters with other healthcare personnel—from check-in clerk to attendant examination room guide, to the nurse, and finally to the physician. They now barely make eye contact. Everybody asks for your name and date of birth and passes you along to the next human contact in the production line. Except for the attendant guide, they stare into a computer screen, asking questions and making entries of the answers or measured vital signs. They sometimes show annoyance when your answers wander or get out of sync with what is required by the computer screen display. Physicians themselves parody the process (20). The patient predictably receives a follow-up survey promising anonymity for answers to questions about satisfaction on scales of 1–5 or 1–10, akin to making a purchase on-line from Amazon or another Internet vendor.

Despite O'Mahony's warnings against digitised medicine, there may be benefit from elimination of physicians, physician assistants, and nurses by Artificial Intelligence-guided robots. Surely, the robots will follow programmed protocols based on individualised big data with fewer errors than human decision makers and just maybe will provide individualised intermittent displays of appropriate empathy. The transition will not harm the fast dwindling number of practitioners of individualised medicine in the industrialised medical enterprise. They will have long departed the scene and not be remembered by anybody except those of us, like O'Mahony's mother, of an age to remember.

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