

COOLERS FOR THE MARK(ET): ORGANIZED MEDICINE AND HEALTH  
CARE REFORM IN THE UNITED STATES AND CANADA

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DEDICATION

to my mother, Mary Leona Mulrooney

## ACKNOWLEDGMENTS

I had the privilege of working with an outstanding committee in the context of a terrific department. What my outside member, “a real doctor,” Al Katz had in common with Jon Goldberg-Hiller, Neal Milner, Deane Neubauer, and Mike Shapiro is that each, in wonderfully distinct ways, inspired me with his graceful teaching, rigorous scholarship, and compassionate way-of-being. In particular, I would like to acknowledge the wise and gentle guidance that I received from my chair, Deane Neubauer. Without Deane’s initial encouragement and his abiding patience, this working-class girl would have never started, let alone finished, a doctoral program.

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## ABSTRACT

Health, pain, suffering, and death may occur spontaneously but quite often these events are non-random societal reflections of who is valued and who is not in a given place at a specific time. If health is socially produced and if the health care sector continues to grow as an increasingly significant segment of wealth generation in post-industrial nations, then these potentially conflicting trajectories make health care reform of increasing consequence for health care systems and the people affected by them. This dissertation charts these competing possibilities by examining some of the discourses of health care reform in the United States and Canada. This project situates physicians as key vocalizers of reform dynamics because what, who, and how they advocate, disdain, and accept is critical to political processes that determine what is instituted, rejected, or adopted within health care systems. A commonality experienced by physicians in the United States and Canada is an arduous professional socialization process that normalizes consoling modalities such as gaming behavior and pecuniary rewards as compensation for suffering. A pursuit of self-regardingness that gets translated into a contest for resources has implications both for health care systems as they reform and for societal conditions that determine health. Physicians act as “coolers” for market medicine by legitimating an inefficient, costly, and inequitable non-system of medical care in the United States. In Canada physicians act as “zombie masters” when they use their professional authority to resurrect for-profit medicine and private insurance as “solutions” to health care crisis generated by structural adjustment. The trajectory of an increasingly commodified health care system is correspondingly class-based health care and/or complete collapse of the system. The unhealthy and unwealthy in both countries will have even less access to medical services just as deleterious impacts of globalization make it all the more likely that those on the peripheries of power due to class, gender, and race/ethnicity social stratifications will have increased need of exactly those

medical services. Physicians as coolers and zombie-masters merit study for the unreflective ways in which professional authority is used to conflate pecuniary interests with that of the common weal.

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## LIST OF ABBREVIATIONS

AARP	American Association of Retired Persons
ABC'd	Abandoned, Betrayed, and Cast aside
ABPS	American Board of Plastic Surgery
AFB	alternative federal budget
AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
AIDS	acquired immune deficiency syndrome
AIMS	Association of Internes and Medical Students
AMA	Alberta Medical Association or American Medical Association
A.M.F.	Adios Mother Fucker
AMPAC	American Medical Political Action Committee
ASPS	American Society of Plastic Surgeons
BC	British Columbia
BCMA	British Columbia Medical Association
B.F.I.	big fuckin' infarct
BMJ	British Medical Journal
BOHICA	Bend Over Here It Comes Again
CCF	Co-operative Commonwealth Federation
CDC	Centers for Diseases Control and Prevention
CEO	chief executive officer
CHST	Canada Health and Social Transer
C.I.	confidence interval
CIA	Central Intelligence Agency
CIHA	Canadian Health Insurance Association
CIHI	Canadian Institute for Health Information
CIR	Committee of Interns and Residents
CLL	Chronic low life
CMA	Canadian Medical Association
CMAJ	Canadian Medical Assication Journal
CMH	Commission on Macroeconomics and Health
CMMS	Centers for Medicare and Medicaid Services
COA	Canadian Orthopaedic Association
COGME	Council on Graduate Medical Education
CPUC	California Public Utilities Commission
CRHA	Calgary Regional Health Authority
CT	computed tomography
C.T.D.	circling the drain
CQHA	Committee on Quality of Health Care in America
DBEDT	Department of Business and Economic Development and Tourism, State of Hawaii
DBI	dirt bag index
DHHS	Department of Health and Human Services
DIAL Syndrome	Dumb In Any Language
DMLR	Doctors for Medical Liability Reform
DNA	"data not available" or deoxyribonucleic acid
DOH UK	Department of Health, Government of the United Kingdom
DTC	direct to consumer
ECFMG	Education Commission on Foreign Medical Graduates
ED	erectile dysfunction

EKG	electrocardiogram
EPSDT	Early and Periodic Screening Diagnosis, and Treatment
ER	emergency room
ESRD	End Stage Renal Disease
FP	family practitioner
FDA	Food and Drug Administration
FPD	Federation of Physicians and Dentists
F.L.K.	funny looking kid
FMAP	federal medical assistance percentage
FUR	Found under Rock
GAO	Government Accounting Office
FY	fiscal year
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GAVI	Global Alliance for Vaccines and Immunizations
GDP	gross domestic product
GOMER	Get Out of My Emergency Room
GP	General Practitioner
GROLIES	<i>Guardian</i> reader of limited intelligence in ethnic skirt
HDI	Human Development Index
HFA	health for all
HIV	human immunodeficiency virus
HMO	health maintenance organization
HRET	Health Research and Educational Trust
HRG	Health Resources Group
HSC	Center for Studying Health System Change
ICU	intensive care unit
IMF	International Monetary Fund
IOM	Institute of Medicine
IPC	Intellectual Property Rights Committee
JAMA	Journal of the American Medical Association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations.
KOD	Keep our Doctors Committee
LMC	Low Marble Count
MCAT	Medical College Admission Test
M.F.I.	mother fucking infarction
MP	Member of Parliament or military police
MRI	magnetic resonance imaging
MSF	Médécins sans Frontières
NAFTA	North American Free Trade Act
NDP	New Democratic Party
NIH	National Institutes of Health
NFL	National Football League
NFN	normal for Norfolk
NLRA	National Labor Relations Act
NP	nurse practitioner
NPC	National Physicians' Committee for the Extension of Medical Service
NSAID	nonsteroidal anti-inflammatory drugs
NYU	New York University
NHS	National Health Service
OHIP	Ontario Health Insurance Plan

OB/GYN	obstetrics and gynecology
OECD	Organization for Economic Cooperation and Development
OHA	Office of Hawaiian Affairs
OMA	Ontario Medical Association
OPEIU	Office and Professional Employees International Union
P3	Public-Private Partnership
PACHA	Presidential Advisory Council on HIV/ AIDS
PAHO	Pan American Health Organization
PC	political correctness
PHC	primary health care
PCR	polymerase chain reaction
PET	positron emission tomography
PhRMA	Pharmaceutical Research and Manufacturers of America
P.L.A.C.E.B.O.PAC	(Physicians Losing All Control over being Economically <u>Buttf@#cked</u> Organization political action committee
PMA	Pharmaceutical Manufacturers Association
PPP	piss poor protoplasm
PRATFO	patient reassured and told to fuck off
PRN	Physicians for Responsible Negotiation
PRS	Paul Revere Society
R&D	research and development
RAD	Reduced Activity Days
SAMA	Student American Medical Association
SARS	severe acute respiratory syndrome
SCHIP	State Children's Health Insurance Program
SHPOS	Sub-Human Piece of Shit
SSRI	selective serotonin reuptake inhibitor
TB	tuberculosis
TEETH	tried everything else try homeopathy
T.F. BUNDY	totally fucked but unfortunately not dead yet
TTFO	told to fuck off
UAPD	Union of American Physicians and Dentists
UCSF	University of California, San Francisco
UFCW	United Food and Commercial Workers
UNICE	Union of Industries of the European Community
UNICEF	United Nations International Children's Emergency Fund
URM	underrepresented minority applicants
USDA	United States Department of Agriculture
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization



## CHAPTER ONE INTRODUCTION

Given that so many of our joys and sorrows, fears and possibilities are contingent on a certain modicum of health or lack of it for ourselves and those we care about, concerns and conversations about health have a compelling force. Moving from highly charged micro-levels of individual experience to a macro-level of analysis, the stakes do not lessen with an understanding of the prevalence of health and disease as functions of how we organize our societies. Robust health, intractable pain, gratuitous suffering, and untimely death may occur spontaneously but quite often these events are non-random societal reflections of who is valued and who is not in a given place at a specific time. If health is socially produced and if the health care sector continues to grow as an increasingly significant segment of wealth generation in post-industrial nations, then these potentially conflicting trajectories make health care reform of increasing consequence for health care systems and the people affected by them.

This dissertation charts some of these competing trajectories of health and health care systems by examining various discourses of health care reform in the United States and Canada. Intrigued by Bruce Kapferer's attentiveness to the "logic of the situation" (1988: xiii) in his comparative analysis of nationalism in Sri Lanka and Australia, my approach is to juxtapose contexts, tactics, rhetoric, data, and dynamics to better understand similarities and differences in the logic of each country with respect to health care reform. While some of the sites of interest in various discourses will be obvious as mainstream, others sites are more fugitive. This project situates physicians as key vocalizers of reform dynamics because what, who, and how they advocate, disdain, and accept is critical to political processes that determine what is instituted, rejected, or adopted within health care systems.

I have chosen to do a comparative study of health care reform in the United States and Canada because each country looms differently in the imagination of the other. A stereotypical view held by many Canadians, that Canada appears indistinctly in the imagination of the United States, was reinforced by President George W. Bush's identification of Canada as one of "our most important neighbors to the north."<sup>1</sup> A synecdoche story from 1969 that expresses an ongoing Canadian obsession with the United States was Prime Minister Pierre Eliot Trudeau's observation that living next to the United States "is in some ways like sleeping with an elephant. No matter how friendly or temperate the beast, one is affected by every twitch and grunt" (O'Malley and Thompson 2003). Characterizations of the American health care system figure prominently in Canadian health care reform discourse and vice versa so one's interest lies in clarifying assertions and aspersions made by each about the other. These strategic representations of comparative health care reform are not just talk, research, and mythology but essential ways of privileging some interests and actors over others. It is important to be mindful that neoliberal perspectives that privilege the market over all other considerations are being trafficked globally. The consequences of the "Washington Consensus" with its logic of structural adjustment in Canada for health and the health care system are significant.

This leads me to my prime contention that health and its discourses are not innocent. Chapter Two considers monotheism, liberalism, and the expropriation of health by medicine as illustrations of the non-innocence of health when it serves ideological thinking. A not-innocuous belief often articulated by organized medicine is that "what is best for the medical profession must be best for the public" (Naylor 1986: 256). Chapter Three links the growth of medicine as a profession to multiple strategies used by organized medicine to advance entrepreneurial medicine. Of particular interest

in this historical chapter are stands against “socialized medicine” by medical associations in the United States and Canada.

Chapter Four examines a cultural context of market fundamentalism by moving from Karl Polanyi’s discussion of economic determinism to the neoliberal regimes of Ronald Reagan, Margaret Thatcher, and Brian Mulroney and then forward to the Wild West economic frontier characterized by Enron. Chapter Five expands these considerations of the impacts of globalization on health and health care systems by examining selected aspects of the global pharmaceutical industry.

While increasing health spending does not lead inevitably to improved health status and universal health care does not guarantee universal good health, it does make a difference whether access to health care is constructed as a human right, public good, or commodity. Each of these constructions of health care is denigrated and affirmed by the discourse of health care reform that is commonly expressed in terms of efficiency, quality, and access as intrinsic elements. Health care system “crisis” that rationalizes reform by appealing to contested notions of efficiency, quality, and access is as non-innocent as health in public policy disputes. The health care system in the United States is situated in Chapter Six as both the site of “the greatest medical care in the world”<sup>2</sup> and as “far and away the most costly, inequitable, and inefficient on this (and perhaps any other) planet” (Evans et al. 2000: 29).

“Academic trauma” experienced by physicians in their socialization process to become doctors and the particular hardships associated with being a physician may be viewed as a kind of currency that physicians pay for their power. A pursuit of self-regardingness that gets translated into a contest for resources has implications for health care systems as they reform and for societal conditions that determine health. This argument outlined in Chapter Seven is made more explicit in Chapter Eight as physicians are shown to act as “coolers” for market medicine in this pursuit of

validation through pecuniary compensation. Illustrations of behavior by physicians that undermine health care systems and subvert possibilities for health include fleeing from providing publicly insured services, generating demand for non-insured procedures and luxury medical care, gaming the system, collective action such as strikes, boycotts, and malpractice activism, and political humor. A privatized, for-profit approach to health insurance and medical services systematically privileges those who are healthy and wealthy over those who are not. Physicians as coolers legitimate this inefficient, costly, and inequitable non-system of medical care in the United States.

While the structural claims of physicians in the United States and Canada may be similar, the content of the discourse changes because of fundamental differences in the logic and culture of each health care system and nation. While physicians also act as coolers in Canada, in Chapter Nine the metaphor of “zombie masters” (Evans et al. 1993) is used to describe organized medicine’s attempts to resurrect for-profit medicine and private insurance. The structural adjustment of Canada produced by Paul Martin’s budget of 1995 exemplified neoliberalism’s ideology of trade liberalism, privatization, deregulation, and shrinking welfare state even as it generated a crisis in the health care system that then was posited to need reform to resolve the very crises brought about by that budget. Basically, a not-perfect but still basically functional system, is systematically being represented by organized medicine as being unsustainable and in crisis as a rationale for dismantling Canada’s system of health insurance so that physicians and other providers can pursue “a right” to entrepreneurial activity.

Despite strong efforts by Physicians for a National Health Program, the hegemonic discursive text of health care reform during the 2004 election in the United States was the market-based proposal propagated by the American Medical Association. In 2004 the Canadian Medical Association used its professional capital to support a legal challenge that threatens the viability of Medicare while its public relations campaigns

undermine confidence and support in a health care system repeatedly characterized as “unsustainable.” Physicians are not the only ones advocating for for-profit medicine and they are not the only coolers and zombie-masters in health care reform initiatives. Their behavior and rhetoric does bear particular scrutiny, however, because of the unreflective ways in which organized medicine often argues for their own perceived self-interest, such as commodified medicine, as if there were no consequences for other real people in their demands. Chapter Ten suggests that the trajectory of an increasingly commodified health care system is correspondingly class-based health care and/or complete collapse of the system. The first is already visible in the United States with excellent care for the wealthy and 45 million uninsured. Canada is struggling with the second as ideologically driven experiments with privatization (especially in Alberta, British Columbia, and Ontario) may through multi-lateral trade agreements (such as the North American Free Trade Act (NAFTA) and the General Agreement on Trade in Services (GATS)) cause medicare to be shredded. The unhealthy and unwealthy in both countries will have even less access to medical services just as deleterious impacts of globalization make it all the more likely that those on the peripheries of power due to class, gender, and race/ethnicity social stratifications will have increased need of exactly those medical services.

From another lens, because I choose to speak through a discourse of the doctoring profession, I find myself in professional literature and in the middle of a profession. It is the nature of professions that their primary conceit is that only those in the profession can understand and speak of what they do. Much ink has been spilled by many sociologists, social historians, and social critics about the arrogant presumption of such a contention and I confess to spilling more. To allow or support by silence such a travesty of social discourse is to ensure that only the self-interested get to speak for

themselves. The most transformative political traditions in the United States and Canada speak precisely against that privileging.

## CHAPTER TWO HEALTH IS NOT INNOCENT

Medicine is a social science, and politics nothing but medicine on a grand scale.  
Rudolf Virchow<sup>3</sup>

In contrast to an everyday understanding of health<sup>4</sup> as a neutral or positive adjective, concept, symbol, process or outcome, this chapter argues that health is not innocent. Whenever health is used instrumentally or is reduced to “operational terms,”<sup>5</sup> then health serves ideological thinking. Instances of the non-innocence of health could be infinitely multiplied. This chapter will consider three illustrations that are topical and politically consequential. Analysis of monotheism, liberalism, and expropriation of health by medicine will serve to carry us behind accepted discursive frameworks that valorize and depoliticize health. A typology of selected discursive approaches to health will be introduced as a heuristic device. Chapter Two will conclude with a brief discussion of Rudolf Virchow, a physician who attempted to expand the warrant of organized medicine to include considerations of monotheism, liberalism, and determinants of health.

Words, semantics, and syntax matter; “grammar is politics by other means” (Haraway 1991: 3). Symbols, including narrative stories, are strategic representations of reality key to problem definition within the public policy arena (Stone 1997). The premise of this chapter is that how we talk about our world makes a difference. Discourse<sup>6</sup> privileges some ideas, structures, power relationships, and people and not others. Differentiated meanings and usages associated with health may be understood as arising from a set of practices that are historically situated and socially constructed. These practices are not random. Michel Foucault’s insight that “power produces knowledge” (Foucault 1977: 27) and his insistence that power and knowledge imply one

another (“power-knowledge”) invite students of health and health policy to interrogate taken-for-granted realms more closely.

Health is a privileged trope with contested interpretations founded on naturalized assumptions that seem to be self-evident. Bryan Turner makes a compelling argument that health is highly contested because it involves “struggles over the moral significance of life”:

Concepts of health and illness stand at the core of the social values of human society because they give expression to many of our fundamental assumptions about the meaning of life and death. A description of health, therefore, tends necessarily to offer a description of ‘the good life’ as a moral state of affairs (2000: 9).

Turner suggests that health concepts can be analyzed along two dimensions—the sacred/profane domain and the individual/collective orientation to health and illness (2000: 11). These distinctions will be of interest as we consider the implications of selected discursive approaches to health as manifest in sacred and secular articulations of clinical and social medicine.

#### Monotheism: The Sin of Sodomy, The Punishment of HIV/AIDS

A normative perspective on what constituted a “moral state of affairs” justified the torture and murder of indigenous people in the New World by the Spanish. Vasco Nunez de Balboa’s soldiers killed hundreds of people in one location by hacking them to death and feeding them to the dogs because Balboa claimed that some of the chiefs were addicted to the “nefarious and dirty sin (of) sodomy.”<sup>7</sup> The Dominican priest, Domingo de Betanzos proclaimed a prophecy during the early years of the conquest that “the Indians were beasts and that God had condemned the whole race to perish for the horrible sins that they had committed in their paganism” (Stannard 1992: 218).

Five hundred years later, the Christian Right<sup>8</sup> still perpetrates verbal<sup>9</sup> and physical<sup>10</sup> violence based on their belief that sodomy is a sin. The political climate in



2003 may be exemplified by senior Republican Senator Rick Santorum who compared homosexuality to bigamy, polygamy, incest, and adultery.<sup>11</sup> White House spokesperson Ari Fleischer related, "The president believes the senator is an inclusive man. And that's what he believes" (Associated Press 2003d). President Bush may believe that Senator Santorum is an inclusive man but Santorum's argument is that current interpretations of privacy laws which protect "homosexual acts" undermine "the basic tenets of our society and the family" (Associated Press 2003c). The Hobson's choice here is that any kind of sex is legitimate as long as it is heterosexual, procreative, and married.

This Santorum/Bush example is significant for demonstrating a particular religious construct at the highest levels of American government culture.<sup>12</sup> Thomas Coburn, Co-Director of the Presidential Advisory Council on HIV/AIDS (PACHA) provides another illustration of an influential Christian Right policy maker that is of particular note due to his occupational standing as a physician.<sup>13</sup> In the context of Coburn's sponsorship of the HIV Prevention Act of 1997, he was interviewed by *POZ*, a publication for HIV positive individuals:

....In his office, I had said to him: "You know that people—gay people—think you hate them and are afraid of you." He responded almost wistfully. "I know that, and I feel so, so sorry about that."

This time he elaborated. "Homosexuals are no less God's children. That choice of lifestyle, or you'd say that situation"—he directed that at me, a gay man, because he considered homosexuality a choice—"is no worse than being unfaithful to my wife or having a standard that is less than what God's standard would be. So do I see gay people as bogeymen and them as a horrible group of people? No!" He was quite adamant. "I actually enjoy the time I spend with people who are gay" (Burr 1997: 6).

One of the most influential health policy makers in Washington, whose authority is strengthened by his professional credentials as a physician,<sup>14</sup> has pity and convivial feelings towards gay people but believes that they are choosing a sinful lifestyle. Causation has implications for prevention and treatment. Sin framed as a lifestyle

choice is different from male with male sexual behavior perceived as a manifestation of complex human experience.

Within a moral economy of sin, the Reverend Billy Graham proclaimed that AIDS was God's way of punishing sodomites and junkies (Burkett 1995: 298). Reverend Jerry Falwell began his portion of a 1983 televised ABC affiliate discussion on "AIDS: The Anatomy of a Crisis" by saying "when you violate moral, health, and hygiene laws, you reap the whirlwind...You cannot shake your fist in God's face and get by with it" (Shilts 1987: 347). The ethical implications for an individual physician within such a fundamentalist sensibility may be illustrated by this physician's refusal to consult on a patient with HIV disease: "Look, I'm not seeing any of these patients, because I believe that homosexuality is wrong and that homosexuality is against my religion, and this is the wrath of God coming down on these people" (Bayer and Oppenheimer 2000: 104).

Moving from clinical medicine to public health examples, Senator Jesse Helms was able to sway the Senate, 94 to 2, to ban any funding for AIDS prevention programs that might "encourage homosexuality." In a 1988 speech "to remove any question" that federal funds would be spent "to condone homosexuality," Helms said:

This subject matter is so obscene, so revolting, it is difficult for me to stand here and talk about it. I may throw up.... This senator will not allow one dollar of taxpayers' money to promote sodomy. This senator is not a goody-goody two-shoes. I've lived a long time...but every Christian ethic cries out for me to do something. I call a spade a spade, a perverted human being a perverted human being (Burkett 1995: 297-298).

What are the implications of being characterized as a "perverted human being"? Bill Kraus, a congressional aid and San Francisco activist expresses internalized homophobia as "when I first heard about AIDS, I thought, Oh, God, they've finally found a disease for the diseased. It rekindles in the psyche all the hateful propaganda that you are sick" (Burkett 1995: 295). A clinical psychologist, Walt Odets, suggests that

having the psychological identity of a gay man and being HIV positive can become conflated:

Homosexuals have often been threatened with, and expected punishment for, their sexuality, and they now often feel, consciously or unconsciously, punished with HIV or AIDS. Getting AIDS may be experienced as a form of redemption, a way of paying dues for one's transgressions. Gays have been shunned by mainstream society, and, in homophobic identification, have often shunned other homosexuals. Gay men now often shun each other because some carry HIV, or are ill, or because some do not carry HIV (Odets 1995: 104).

Punishment and redemption, being shunned for having HIV disease and for not having HIV disease, fear of becoming infected and desire to become infected—all these complicated human responses are ways of trying to understand and live out the good life. Conflating sexual behavior with sexual identity and disease with sin may be strategies to make the world seem more intelligible but carry a high cost. Situating health as a marker for righteousness necessitates medical surveillance as social control.

What might such righteousness look like? An April 2003 *New York Times* article reported that HIV researchers seeking federal funding have been unofficially warned to avoid "certain key words" in their grant applications. Hot button words include "sex workers," "men who sleep with men," "anal sex," and "needle exchange."

In another example of the scrutiny the scientists described, a researcher at the University of California said he had been advised by an N.I.H. project officer that the abstract of a grant application he was submitting "should be 'cleansed' and should not contain any contentious wording like 'gay' or 'homosexual' or 'transgender'" (Goode 2003).

Euphemisms to avoid "contentious" wording and presumably people has ominous overtones when considering the slippery slope from "cleansing" language to "cleaning" people.<sup>15</sup>

Alfred Sommer, Dean of the Bloomberg School of Public Health at Johns Hopkins University, warned of a "pernicious sense of insecurity" among researchers related to the notion that "grants might be subject to political surveillance:"

Dr. Sommer said that if researchers feared that federal support for their work might be affected by politics, whether it was true or untrue, it could take a toll. "If people feel intimidated and start clouding the language they use, then your mind starts to get cloudy and the science gets cloudy," he said, adding that the federal financing of medical research had traditionally been free from political influence (Goode 2003).

Perhaps more remarkable than the irony of public health surveillants protesting political surveillance is the ahistorical claim<sup>16</sup> that medical research has been "traditionally free from political influence." Much of the discussion of professional medical labor in subsequent chapters will explore historical and current political and economic tensions inherent in the medical industrial complex in the United States and Canada.

It is also ominous that in his argument critiquing the sanitizing of real people and actual context through the use of imposed euphemisms, Sommer uses "political influence" as code for the Christian Right in the United States. The Christian Right is becoming increasingly organized as the Traditional Values Coalition<sup>17</sup> is circulating a list of nearly 200 scientific researchers conducting federally funded research described as "prurient" (Herbert 2003). The rhetorical possibilities of this controversy are as limitless as they are strategic. Deploring "these smarmy projects," Traditional Values Coalition's executive director, Andrea Lafferty, described the NIH as a "national endowment for the arts with a chemistry set" that "obviously requires more adult supervision" (Clark 2003). In response to this "hit list," Democratic Representative Henry Waxman accused the coalition of "scientific McCarthyism" (Clark 2003).

What, then, is the underlying cosmology that makes it possible for male with male sex to be considered a sin and HIV/ AIDS to be characterized as a punishment for sinful behavior? What are the sensibilities that are at risk of being offended? Warren Magnusson describes the ideological underpinnings of Western culture as monotheism<sup>18</sup> (1996: 40). Johan Galtung situates monotheism as a "hard religion" as he makes a distinction between "hard" and "soft" religions. The hard version has among its

characteristics a God that is transcendent, outside and above, and God has Chosen People. The soft version features God that is immanent, inside all life, and People have Chosen Gods (Galtung 1998). Galtung describes transcendentalism as a “catastrophic idea;” the consequences of a god outside and above makes it increasingly possible “some people will be seen as closer to that God than others” (1990: 296). Combined with sharp dichotomies between good and evil influenced by dualism and Manichaeism, hard versions of Christianity, Islam, and Judaism, can reinforce hierarchies of all kinds.<sup>19</sup> The Christian Right is an example of monotheism in its harder version; within this framing, health becomes a sign of innocence as disease is God’s punishment for sin.

Galtung’s description of a continuum of hardness and softness, even within traditions considered to be mainly hard or soft, helps to explain diverse responses of care, cure, and compassion found among individuals and communities whose motivations are influenced by the sacred. Thus, monotheism as underlying ideology could explain a physician who refuses to treat a gay patient with HIV disease, medical research that is sanitized to conceal its target population, and public health interventions such as abstinence-only sex education<sup>20</sup> that is privileged as a funded export across the globe.<sup>21</sup> At the same time, a softer version of monotheism also undergirds liberation theology, which physician and anthropologist, Paul Farmer, uses to explicate the structural violence of poverty that causes AIDS (Farmer 1997).

HIV/ AIDS is a particularly rich, but not unique,<sup>22</sup> illustration of monotheism as a dominant discursive framework. It not only serves as an example of monotheism as hard religious description of disease as sin as discussed above, but it also often demonstrates monotheism as a single variable narrative of causation. Scientific, secular monotheism often models HIV/ AIDS entirely within a reductionist paradigm that privileges discrete, quantifiable etiologies that are only biological or behavioral.<sup>23</sup> Characteristics of this approach are outlined within the biomedical and new public

health cells in Exhibit 2.2 (Parts A and B), which may be contrasted with polytheistic approaches typical of complementary and social production of health outlined in this typology.

### Liberalism: The Virtue of Individualism, The Reward of Wealth

This section will focus on Bill Gates's philanthropic activities in global health as an entry point to consider liberalism as a hegemonic discursive framework. While Gates is the most spectacular example of success in the New Economy, other compelling scenarios could also have been presented by considering philanthropists<sup>24</sup> such as Paul Allen (Microsoft), Larry Ellison (Oracle), George Soros (currency speculator), or Ted Turner (media mogul). This discussion of Bill Gates is intended to be understood in the context of Chapter Three, which identifies John D. Rockefeller and Andrew Carnegie as key historical influences on the trajectory of medical education and research in the United States and Canada in the 20<sup>th</sup> century. Neoliberalism as an underlying ideology of globalization along with its implications for health and health care systems will be explored in Chapter Four.

It is difficult to resist the heart-warming photograph of Bill Gates carefully dropping life-saving oral polio vaccine into the open mouth of the small child with wide eyes in New Delhi. This picture illustrates the "World Without Polio" campaign, a 750 million dollar commitment by the Bill and Melinda Gates Foundation, to eradicate polio globally by 2005.<sup>25</sup> Who could argue with their mission statement of improving equity in global health "because the life and potential of a child born in one place is as valuable as that in another"? Who could not be impressed by a foundation created as recently as January 2000 and yet with the world's wealthiest endowment of "approximately \$25 billion through the personal generosity of Bill and Melinda Gates"?<sup>26</sup> How can this philanthropy to benefit global health objectives not be innocent and even praise-worthy?

In fact, National Public Radio presented an “Analysis: New Generation of Philanthropists Shake Up Scientific Research” that was congratulatory in its tone. The story opens with the statement that “Rockefeller and Carnegie oversaw their scientific charity from a distance” quickly juxtaposed with sounds of Bill Gates “quizzing Dr. Xavier Gomez Olive” at a malaria clinic in Mozambique (Hamilton 2003). The salient point for this NPR story is that Bill Gates, Larry Ellison, and Paul Allen are using their wealth “to turbocharge the conservative world of scientific research” (Hamilton 2003). The Gates Foundation, The Ellison Medical Foundation, and the Allen Institute for Brain Science are entrepreneurial, willing to support “risky” projects, and share a belief that “technology can solve almost any problem” (Hamilton 2003). The Ellison Medical Foundation, for example, is spending \$20 million dollars a year on research into aging, including investigations into an enzyme called telomerase. Richard Sprott, who moved to the Ellison Foundation from the National Institutes of Health, opines that “if you could find out how to selectively turn off telomerase in cancer cells, you’d have a silver bullet to cure a wide, wide array of cancers” (Hamilton 2003).

Public health physicians associated with the Gates Foundation, Gordon Perkin and William Foege, describe the overarching objective of the Global Health Program as “Global Health Equity” (McCarthy 2000: 153). The means for achieving this objective are research and technology developed into “tools” such as vaccines that will have a long-lasting impact. Perkins notes that this focus on tools “reflects Bill Gates interest in technology—‘You only have to develop such tools once and then they’re going to benefit many people in the future’” (McCarthy 2000: 154).

When asked about the history of his interest in global health issues, Bill Gates relates the “Aha moment” for him as arising from reading the *World Development Report: Investing in Health*<sup>27</sup> (World Bank 1993). In an interview with Bill Moyers, Gates says that when he first saw a graph that showed half a million children per year died of

Rotavirus, his first response was disbelief because he had never heard of it before. Moyers quotes Oscar Wilde, “it’s the mark of a truly educated man to be deeply moved by statistics” and Gates admits to being “mathematically literate” (Moyers 2003). It is a riveting conversation even to read and yet his transformative moment is based on a document that advocates market responses to diseases caused by poverty made infinitely worse by structural adjustment programs<sup>28</sup> imposed by its author, the World Bank. Critics of World Bank policies<sup>29</sup> point out that income per capita in Africa is lower today than twenty years ago when structural adjustment programs began, life expectancy declined in 31 African countries between 1995 and 1998, and Africa spends \$14 billion each year repaying debts while only receiving \$12.7 billion in aid (New Internationalist 2002: 13). Bill Gates learning about health from the World Bank might be akin to taking a first aid course from a serial killer or at the very least, an extremely negligent babysitter.

This is not to take Bill Gates’s transformative insight into the horrific plight of people living in poverty lightly. In this interview Gates does not give primacy to the “health will create wealth” accounting argument or that “health will protect us in the industrialized countries against infectious others” argument that attempts to mobilize support for global health initiatives. Instead, Gates argues that people must be considered in a non-instrumental fashion:

The right argument is, you know, this mother's child is sick. And that child's life is no less valuable than the life of anyone else. And the world has plenty of resources to go solve these problems (Moyers 2003).

The cognitive dissonance is that if every child, every person, has a life of equal value, should not every one have access to the essential requirements that sustain life? The world does have enough resources to sustain all, but currently the distribution of the world’s wealth is skewed.



While the net worth of Bill Gates was 90 billion dollars in 1999, there were 2.8 billion people living on less than two dollars a day in that same year. Of these people trying to survive at the economic margins, 1.2 billion were trying to do so on less than one dollar per day (United Nations Development Programme 2002: 17). In Sub-Saharan Africa, 46.7 percent or 300 million of the population subsisted on less than one dollar per day in 1999 (United Nations Development Programme 2002: 18).

**Table 2.1 Net Worth of William H. Gates, III, Years 1996-2004\***

Year	Net Worth in Billions
2004	48
2003	40.7
2002	52.8
2001	58.7
2000	60
1999	90
1998	51
1997	36.4
1996	18.5

\*Source: [www.forbes.com](http://www.forbes.com), accessed September 25, 2004.

Another way of visualizing this dynamic is by using the United Nations Development Programme's Human Development Index (HDI), which calculates a variety of demographic, economic, and social indicators.<sup>30</sup> Using data from 2000, the country with the highest HDI was Norway with a score of 0.942 (United Nations Development Programme 2002: 149). If we take the twenty countries with the lowest HDI, their cumulative GDP only slightly exceeds Bill Gates' net worth for the same time period. In 2000, the cumulative GDP for these twenty countries was 61 billion for a total population of 266.3 million people. Bill Gates's net worth was 60 billion for a family of four. Bill Gates's net worth in 2004 is a more modest 48 billion for a family of five.

**Table 2.2 Comparison of Twenty Countries with Lowest Human Development Index (HDI) Value with Bill Gates, Year 2000\***

Country	GDP in US\$ billions	Total Population in millions	HDI
Sierra Leone	0.6	4.4	0.275
Niger	1.8	10.8	0.277
Burundi	0.7	6.4	0.313
Mozambique	3.8	18.3	0.322
Burkina Faso	2.2	11.5	0.325
Ethiopia	6.4	62.9	0.327
Guinea-Bissau	0.2	1.2	0.349
Chad	4.1	7.9	0.365
Central African Republic	1.0	3.7	0.375
Mali	2.3	11.4	0.386
Malawi	1.7	11.3	0.400
Rwanda	1.8	7.6	0.403
Angola	8.8	13.1	0.403
Gambia	0.4	1.3	0.405
Guinea	3.0	8.2	0.414
Benin	2.2	6.3	0.420
Eritrea	0.6	3.7	0.421
Cote d'Ivoire	9.4	16	0.428
Congo	5.6	50.9	0.431
Senegal	4.4	9.4	0.431
Total for 20 countries	61	266.3	
Bill Gates (Year 2000)	60	Family of four	
Bill Gates (Year 2004)	48	Family of five	

\*Sources: Country data obtained from the United Nations Development Programme. 2002. *Human Development Report 2002: Deepening Democracy in a Fragmented World*. New York: Oxford University Press. GDP statistics are from Table 12, p. 193. Population data are from Table 5, p. 165. HDI values are from Table 1, p. 152. Gates data are from [www.forbes.com](http://www.forbes.com) accessed September 25, 2004

Bill and Melinda Gates personally endowed their foundation with over 24 billion dollars in 2000 but it was from a baseline net worth of 90 billion in 1999. A vital question is: to what extent is the wealth of the North (and not just that of Bill Gates) contingent on the suffering of people of the South? Why should the Bill and Melinda Gates Foundation be valorized every day by advertisement/ education about its global health program on National Public Radio rather than asking to what extent would the charity of global health programs be needed if there was more equitable access and distribution of the world's resources? Is it possible to achieve "global health equity" within a global economic system that rewards one individual with \$90 billion dollars while literally billions of other people try to subsist and often die for lack of adequate food, water, sanitation, and shelter?

Bill Gates is the poster child for capitalism; his phenomenal success is the goal of many an entrepreneur. That makes it all the more powerful when he attributes the appalling infant mortality rates in developing countries to "a failure of capitalism"<sup>31</sup> (Moyers 2003). Gates affirms that "capitalism is this wonderful thing that motivates people, it causes wonderful inventions to be done" but acknowledges that in the health arena, the incentives for technical progress are attuned with what will make a profit. Gates says:

Here what we have is, with the plural disease, not only don't the people with money have the disease, but they don't see the people who have the disease. If we took the world and we just re-assorted each neighborhood to be randomly mixed up, then this whole thing could get solved. Because you'd look out your window and you'd say, you know there's mother over there whose child is dying. You know let's go help that person. This problem, the lack of visibility, it's partly you don't read about it, you don't see it. It's the silence that's allowing this to happen (Moyers 2003).

Would things be better if Bill Gates's \$53 million, 66,000 square feet home<sup>32</sup> was randomly mixed up next door to a dirt-floored, grass thatched home? Could the mother next-door come over to borrow some clean water<sup>33</sup> to keep the baby from getting sick in

the first place? If this juxtaposition sounds ludicrous, it is no less so than the assumption that a bit more awareness to generate a bit more charity to fund scientific research and improved technical devices will solve the predictable consequences of deprivation and death caused by how the global political economy is organized.

Bill Gates's argument is that if people know about a life-threatening situation, they will act on it. Within a North American culture saturated with mass media, is it true that people really don't know that people are in need across the globe? Is it the case that the growing numbers of homeless<sup>34</sup> and hungry<sup>35</sup> that must be stepped over on the streets of North America and paged over even in glossy fashion magazines<sup>36</sup> are literally invisible? What are the conditions that make it possible for people in North America to imagine and treat people as if they are not worthy to be seen? Could it be that recoding the homeless as criminals<sup>37</sup> rather than as unneeded labor/unsatisfactory consumers in the global economy is a somewhat similar process to depoliticizing global health issues? The "silence" that permits us to avoid seeing the mother with the dying baby and the hungry person dining out of the dumpster is inexorably bound with an unexamined faith in capitalism and its handmaidens, science and technology. Mr. Gates's description of the failure of capitalism as people on the periphery being overlooked because they are not seen on the individual level discourages visibility of the workings of the political, economic, social, and cultural systems causing their misery and invisibility.

An unexamined faith in capitalism is made possible by an ideology of liberalism that underpins American, and increasingly Canadian, culture. Central tenants of liberalism are competitive individualism, the right to private property, limited government, and the primacy of the market to coordinate economic, social, and political life (Greenberg 1989: 36-42). Of particular importance are property rights, considered by John Locke and his seventeenth-century contemporaries to be sacred and natural, which precede all other claims. Creel Froman points out that James Madison's *Federalist Paper*

No. 10 is a candid statement that “politics is about property; government is to protect property” (1984: 14). Edward Greenberg argues that liberalism’s most important function is to establish an artificial separation between economics and politics so that the government has no legitimacy in the economic realm, unless it is to guard capital (1989: 47). This helps to explain the 1857 Supreme Court enforcement of the Bill of Rights against an Act of Congress when it ruled in favor of Dred Scott’s master to protect his property rights over Dred Scott, a slave considered to be property (Sandel 1996: 38).

Warren Magnusson argues “liberals regard the state system and the market economy as expressions of universal human rights.” The state and the market have been endowed with a certain religious quality so that “those who refuse these institutions are regarded as enemies of human rights, and, hence, as inhuman beings” (1996: 41). The privileging of the market and property rights over any other considerations may help to explain contradiction between the rhetoric of health as a fundamental human right<sup>38</sup> and the reality of widely divergent patterns of suffering and death among the rich and poor.<sup>39</sup>

These points can be powerfully demonstrated at the intersect between generalized intellectual property rights and their specific application in the health/medicine/ pharmaceutical arena. It is noteworthy that The Center for the Moral Defense of Capitalism opposed the Microsoft antitrust case as “an abridgement of the freedom of production and trade and an interference with the right to acquire and possess property” (Provenzo 2002: 1). This advocacy group testified that Microsoft “personified” the free market rather than being an impediment to it. As a personification of the free market, Microsoft’s charitable efforts are controversial. Donations of up to \$1 billion annually in software to the non-profit sector are being praised by the recipients and criticized by developers of “open-source” software as a bid to extinguish the free software market (Markoff 2003). Critics charge that although Windows software runs on

90% of the world's personal computers, Microsoft tries to gobble up the rest of the market by undercutting its price or giving software away free to governments and institutions. Linux, the biggest open-source software competitor to Microsoft, was once referred to by Steve Ballmer, Microsoft's Chief Executive Officer, as "a cancer that attaches itself in an intellectual property sense to everything it touches" (Fuller 2003).

Using the metaphor of cancer to describe Linux reminds us of the power of health imagery to sway imaginations and underscore the need for action. The ambiguous nature of Microsoft's philanthropy is also instructive. Critics of Microsoft agree that the donations will be helpful to agencies with severe financial constraints but at the same time they worry that the software will stop after people are "hooked" as a strategy for unfair competition<sup>40</sup> (Markoff 2003). The short term gain for the individual non-profits who directly benefit from the free software versus the long term gains for the non-profit sector from development of open-source software might have some parallels with the Bill and Melinda Gates Foundation's philanthropic activities.

The investment of \$205 million in nine pharmaceutical companies, including \$76.9 million into Merck shares, \$37.3 million into Pfizer, and \$29.7 million into Johnson & Johnson (Teather 2002) by the Gates Foundation is strongly consistent with these property understandings. *The Wall Street Journal* noted "Mr. Gates' staunch support of strict intellectual-property protections for drugs in poor countries" aligns with the interests of intellectual property rights for Microsoft (Bank and Buckman 2002). The Gates Foundation was also a major supporter for the Commission on Macroeconomics and Health, which made a strong defense of intellectual property rights as critical to continued investment in drug research and development (Bank and Buckman 2002). James Love,<sup>41</sup> director of the Consumer Project on Technology, observed that officials from Botswana and other African countries were reluctant to press for generic drugs in fear that it might hinder their chances for funding from the Gates Foundation (Bank and

Buckman 2002). An official from Botswana with its 5.3 billion GDP,<sup>42</sup> life expectancy at birth of 40.3 years<sup>43</sup>, and 38.8% HIV prevalence<sup>44</sup> in 2000 is understandably worried about being overlooked for grants from this foundation so influential in funding global health initiatives. This could be another example of a short-term gain (immediate assistance in the form of grants and access to drugs) trumping longer-term benefits (comprehensive changes to allow generic drugs to be produced locally.)<sup>45</sup>

Conflict of interest<sup>46</sup> might also arise from the fact that the Gates Foundation is one of the five renewable partners (along with WHO, UNICEF, the World Bank, and The Vaccine Fund) of the Global Alliance for Vaccines and Immunizations (GAVI) which will need to purchase drugs from the same companies that it now has shares in. The Gates Foundation is also on the board for the Global Fund to Fight AIDS, Tuberculosis and Malaria which is expected to become a major buyer of drugs to fight those diseases (Bank and Buckman 2002). *The Guardian* pointed out pre-existing links with the drug industry with Merck chief executive, Raymond Gilmartin, joining the Microsoft board in 2001 and assistance given to Merck with AIDS programmes in Botswana by Bill Gates (Teather 2002). A dilemma with the commingling of interests supported by a “magic bullet” approach to global health at the governmental, civil society, biomedical, and industrial levels is that any other approach is delegitimized.<sup>47</sup>

The equal footing of the Gates Foundation with such organizations as the World Bank and WHO within GAVI is based solely on its fiscal might. This might allows the Gates Foundation a disproportionately large influence in setting the content and process of what will be the global health agenda for the foreseeable future. More importantly, this powerful, private foundation seamlessly reinforces the assumptions and norms of secular monotheism embodied in the biomedical perspective thereby contributing to its hegemonic vibrancy. On January 26, 2003 Bill Gates announced at the World Economic Forum<sup>48</sup> that the Bill and Melinda Gates Foundation was setting up a US \$200 million

fund to research diseases that affect the world's poor. Gates announced the explicit intention to create a "new field of endeavor called global health science." Billing this initiative as "finding specific solutions to the hardest problems" (Ashraf 2003: 404), the assumption is that the problem is scientific and that research will solve it. The methodology of the Gates Foundation has been called, rather admiringly, "venture philanthropy":

It treats grant recipients as business partners, auditing their performance and demanding that they contribute whatever they can to the project. Governments, however strapped, typically have to increase their own health spending to qualify for help (Cowley, Masland, and Underwood 2002).

This New Economy philanthropy might genuinely alleviate the suffering of some people but it is still a form of colonialism,<sup>49</sup> if by colonialism we mean the rule of vulnerable people for the economic benefit of those who rule. What does it say about how power is flowing when Gates Foundation grantees such as Johns Hopkins University researchers describe their \$40 million project as "the measles empire" (Hamilton 2003) while Bill Gates "quizzes" or publicly interrogates an African physician on his treatment plan in a context that Gates might not fully understand? While colonialism was historically associated with the activities of European nation-states, it does not seem a stretch to put the Gates Foundation in the same category as a sovereign country when its \$100 million contribution to the Global Fund to fight AIDS, Tuberculosis, and Malaria will exceed England's \$40 million and Germany's \$48 million payments (Tagliabue 2003). While acting as a peer or even as a superior in giving power to these advanced industrialized countries, Gates Foundation might be also exemplified by comparing the total of \$6.2 billion (of which \$3.2 billion was allocated for health) distributed since inception (Table 2.3) with the gross domestic products of the countries listed in Table 2.2. Huge amounts of money need to be disbursed annually in order to



maintain the foundation's tax exempt status and 80% of its grants utilize private-public partnerships for grant administration: "the foundation needs a big conduit to accommodate its big grants" (Strom 2003). How is it possible for a country in sub-Saharan Africa to choose which urgent priorities to address in a resource-scarce context where there is an expectation of "venture philanthropy" guidelines in exchange for a grant? Is it to be a comprehensive primary care program for a specific rural area or a blitz to immunize every child in the nation? Who gets to decide whose needs are most urgent? Who gets to decide how best to respond?

Vertical approaches to specific diseases that are measurable,<sup>50</sup> within programs that are auditable, with governments that can afford matching funds, may be satisfying to the donors but they may not meet the long-term needs of a specific community. People may acquiesce to vertical programs in increasingly difficult times, however, those whose choices are already constrained may lose further agency as their health care becomes increasingly fragmented and less of a comprehensive "system." Solutions generated by the biomedical and business elites will be rooted in science, technology, and industry. They will not be sensitive to queries about how land and the means of production are distributed.<sup>51</sup> One does not require a conspiracy theory to see here an example of a confluence of interests that favors market-based solutions over those rooted in sharing of power and resources. As Bill Gates is described as a "demigod in India"<sup>52</sup> (Andrews 2003) and lauded in the *New York Times*,<sup>53</sup> fundamental assumptions underpinning the medical-industrial complex organized around global health remain unexamined.

Not only are basic assumptions about preferred biomedical approaches to health difficult to question, but the extent to which the Bill and Melinda Gates Foundation is inexorably intertwined with macro and micro institutions is astonishing.

**Table 2.3 Bill and Melinda Gates Foundation Grants by Category as of June 2003\***

Global Health	\$3,215,501,887
Education	\$1,837,100,276
Special projects	\$488,781,346
Pacific Northwest	\$477,965,093
Libraries	\$227,018,570
Employee Matching Gifts and Sponsorships	\$1,643,856
Total Grants	\$6,248,011,028

\*Source: Bill and Melinda Gates Foundation website, accessed September 7, 2003  
<http://www.gatesfoundation.org/Grants/default.htm?showYear=2003>

A closer look at exactly where some of this \$6.2 billion went is instructive. United Nations agencies, such as the United Nations Development Programme and the World Health Organization, received millions. More surprising is that the World Bank and World Economic Forum received half a million each. A host of research and policy organizations working on global health issues received funding as did many “on-the-ground” non-governmental organizations such as CARE, World Vision, and Save the Children. Other research and policy organizations that received funding including the Brookings Institute, the Council on Foreign Relations, the National Center for State Courts, and the Foundation Center. The University of Washington has been awarded more than 55 million dollars, Johns Hopkins University 40 million dollars, and Duke University more than 35 million dollars. Harvard University received 4 million dollars plus \$650,000 over one year to support the Commission on Macroeconomics and Health.

**Table 2.4 Bill and Melinda Gates Foundation Grants to Support the Commission on Macroeconomics and Health (CMH)\***

Date	Grantee	Amount	Purpose
June 1, 2000	Harvard University (Cambridge, MA)	\$650,000 (1 year)	To support the CMH
June 1, 2000	University of Lausanne (Switzerland)	\$350,000 (1 year)	To support the CMH
Nov. 21, 2000	Indian Council for Research on International Economic Relations (New Delhi, India)	\$100,000 (1 year)	To provide a research study to CMH on current state of health system in India
March 15, 2002	World Health Organization (Geneva)	\$10,320,000 (2 years)	To support follow-up of CMH report at country, regional, and global levels
Total		\$11,420,000	

\*Source: Data obtained from the Bill and Melinda Gates Foundation website, accessed September 7, 2003, <http://www.gatesfoundation.org/Grants/>

Gates Foundation support for the Commission on Macroeconomics and Health with over \$11.4 million in grants is significant not only in dollar amount but in legitimating a market-based approach to health advocated by the World Bank. The Gates Foundation consciously tries to “leverage” the impact of their actions by attracting “investors” to their preferred approaches. As William Foege explains:

For example, when the Gateses give money for the development of an AIDS vaccine, suddenly other donors give money because they see this must be an important issue and there must be a possible solution, or Bill and Melinda Gates wouldn’t be investing in it. So they give credibility to this area in a way that no one ever has before (McCarthy 2000: 154).

The credibility of the work of the Commission on Macroeconomics and Health is strengthened by the Gates Foundation’s imprimatur.

In terms of global health policy, the voices that are legitimated by this report are economists, researchers, and consultants affiliated with multilateral lending agencies, the International Monetary Fund, and the World Bank. Conspicuously absent are “representatives of non-governmental organizations, political parties, unions, professional organizations in medicine and public health, organizations of indigenous or

ethnic minorities, activists in occupational and environmental health, and members of the worldwide movement targeting economic globalization” (Waitzkin 2003: 523). As a long-standing critic of the contradictions of trying to provide health care in a capitalist system,<sup>54</sup> Dr. Howard Waitzkin notes the report’s logically inconsistent recommendations that favor intellectual property rights that protect drug patents while recommending access to medications for endemic diseases (2003: 526). This is significant to note for prospective discussions of globalization and the global pharmaceutical industry forthcoming in Chapters Four and Five. Of relevance to latter chapters in this dissertation is support given by the Commission on Macroeconomics and Health for economically bifurcated health care systems justified as “efficient” but that erode “the ethical and economic underpinnings of national health programmes based on solidarity, where the system’s quality depends on participation by both rich and poor” (Waitzkin 2003: 523).

Moving from international to national spheres of influence, the Gates Foundation has given 200 million dollars to the Foundation for the National Institutes of Health as well as smaller grants to the National Institutes of Health, Institute of Medicine, CDC Foundation, and National Academy of Sciences. Many states have been awarded multi-year, multi-million dollar grants for professional development and demonstration projects in education. Schools at every level in the Pacific Northwest have received support as have community projects involving recreation, arts, health and human services.

Direct subsidy of mass media by the Gates Foundation includes 11 million dollars to KCTS Television to support the conversion to digital broadcasting and over 1.3 million dollars over 5 years to National Public Radio “to increase understanding of global health issues.” The broadcast of Bill Moyers’s interview of Bill Gates was supported by a \$488,200 grant to the Mailman School of Public Health at Columbia

University.<sup>55</sup> The ability to shape public perceptions through mass media is not to be underestimated as public relations campaigns funded by organized medicine and the global pharmaceutical industry will demonstrate in ensuing chapters.

A careful consideration of Exhibit 2.1 might support the contention that one would be hard pressed to find a researcher, practitioner, or instructor working on global health issues who is not affiliated in some capacity with one or more agencies of the United Nations, World Bank or a regional development bank, federal, state, or local government, academic health facility or university, research, policy, professional or advocacy organization, or direct service non-governmental organization that has received, is receiving, or has dreams of receiving grant support from the Gates Foundation. After the national trauma of the events of September 11, 2001, it would be difficult not to have affection for a foundation that could give two grants of one million dollars each within two days of the event for immediate assistance. In many geographical areas it would be hard to ignore the influence of the Gates Foundation on educational reform attempts and increased resources that might benefit one's children. If one lives in the Pacific Northwest, it might be difficult to discover a site in daily life untouched by Gates's Foundation grant-making. We are often more tempted to lick than bite the hand that feeds us. This theme will be revisited in Chapter Five in a consideration of medical professionals and the pharmaceutical industry in the context of globalization.

Moving beyond trying to sort out human responses to complex situations that include self and group interest, the Bill Gates phenomenon of massive wealth accumulation and distribution illustrates a core problem of liberalism. The radical privileging of individualism leaves liberalism with the question of what to do with individuals who are so far above the market and their communities?<sup>56</sup> How are we to think of a George Soros who made a billion dollars in a day by speculating against the

British pound to the dismay of the British government who later warns of the threat of unbridled capitalism to the world?<sup>57</sup> Or a Ted Turner<sup>58</sup> who can donate \$1 billion dollars to the United Nations as a private citizen in 1997 and prepare to pitch in another \$34 million in 2000 to make up the shortfall owed to the United Nations by the United States?<sup>59</sup> Concerns about disproportionate power and wealth of individuals and corporations are not unique to the 21<sup>st</sup> century. Chapters Three and Four will provide further illustrations of “regulatory regimes”<sup>60</sup> as states attempt to grapple with questions of how best to enable a “good life” for various constituents.

**Exhibit 2.1 Illustrative Examples of Financial Support by the Bill and Melinda Gats Foundation to Key Sectors and Influential Constituents:\***

Sector	Grantee	Amount \$	Purpose
Global	United Nations Development Programme	2,808,333 (3 years)	To support the United Nations Millennium Declaration's movement towards achieving the Millennium Development Goals (New York)
	World Health Organization Geneva	5,000,000 (5 years) 4,221,995 (2 years)	To build mapping tools for rapid analysis of infectious disease To support a project to control Epidemic Meningococcal Disease Surveillance in the African Meningitis Belt
	World Bank New York, NY	560,000 (3 years)	To improve the health of poor and protect poor from further impoverishment through illness
	World Economic Forum Geneva	500,000 (2 years)	To foster greater business engagement globally in the fight against HIV/AIDS, tuberculosis and malaria
	Vaccine Fund Seattle, WA	3,500,000 (1 year)	To support the Global Alliance for Vaccines and Immunizations work plan
NGOs	CARE Atlanta, GA	2,750,000 (1 year)	To implement a comprehensive response to drought emergencies and food shortages in Southern and Eastern Africa
	Save the Children Federation Westport, CT	1,500,000 (1 year)	To support interventions in Malawi, Zambia, and Zimbabwe to help preempt famine and prevent further disaster
	World Vision Federal Way, WA	250,000 (1 year)	To provide 10,000 vulnerable farm households in Zambia and Southern Malawi with seeds for drought-resistant crops
	International Rescue Committee NY, NY	500,000 (1 year)	To respond to the volcano in Goma, Congo and save people's lives through the provision of water, sanitation, shelter, and basic health care services
Health Research/ Policy	Management Sciences for Health Boston, MA	29,957,826 (5 years)	To establish the Gates Drug Management Center to provide sustainable access to priority drugs, vaccines and essential health commodities in underserved areas
	Center for Global Development DC	1,900,000 (2 years)	To create a network of experts who will systematically develop and implement a research agenda on key policy questions in global health
	European Center for Population and Development	2,000,000 (3 years)	To strengthen the availability and efficient use of human, institutional, and financial resources for reproductive health supplies through the development of a web-based information system

Sector	Grantee	Amount \$	Purpose
	Global Health Council Washington, DC	4,800,000 (3 years)	To support the expansion and networking efforts on key global health issues
	Global Forum for Health Research Geneva	1,000,000 (2 years)	To support an initiative on public-private partnerships for the promotion of global health equity
	National Council for International Health	300,000 (1 year)	For general support (Washington, DC)
	International Society for Infectious Diseases	963,138 (2 years)	To support ProMed-mail, an email based emerging disease detection and reporting system (Boston, MA)
USA	New York Times Neediest Cases Fund	1,000,000 (1 year)	Granted on Sept. 13, 2001 to support the 9/11 Fund established for families of the September 11 <sup>th</sup> attacks on the World Trade Center
	American Red Cross Seattle, WA	1,000,000 (1 year)	Granted on Sept. 13, 2001 to support the National Disaster Relief Fund in the wake of the September 11 <sup>th</sup> attacks on the World Trade Center and Pentagon.
	Helen Keller International New York, NY	1,000,000 (2 years)	Granted on Nov. 16, 2001 to rebuild infrastructure needed to maintain global health operations after the September 11 <sup>th</sup> destruction of their global headquarters office in New York.
	National Institutes of Health Bethesda, MA	3,505,000 (3 years)	To reassess and update the World Bank's 1993 publications: <i>Disease Control Priorities in Developing Countries</i> and <i>World Development Report 1993, Investing in Health</i> .
	Foundation for the National Institutes of Health Bethesda, MA	200,000,000 (10 years)	To develop a funding mechanism that will accelerate scientific progress in addressing the needs of the most impoverished
	National Academy of Sciences	10,000 (1 year)	For general support (Washington, DC)
	Institute of Medicine Washington, DC	404,687 (1 year)	To convene an international symposium on new frontiers in contraceptive research. They have also received \$200,000 over 1 year to support a meeting on antimalarial drugs and drug resistance
	CDC Foundation Atlanta, GA	1,000,000 (1 year)	To support the CDC Foundation's collaborative efforts with the United States Department of Health and Human Services to begin rebuilding the health care infrastructure in Afghanistan



Sector	Grantee	Amount \$	Purpose
Education	California County Superintendents Educational Service Assn.	18,151,500 (3 years)	To provide superintendents and principals from public and private schools access to quality leadership development focused on technology integration and whole systems change
	Florida Department of Education	5,499,727 (3 years)	New Hampshire, Kentucky, Delaware, Nebraska, Kansas, Wisconsin, Texas, Minnesota, Alaska, New York, New Mexico, Arizona, Nevada, Montana, Virginia, Georgia, Tennessee, Connecticut, and Michigan are among the states that have received similar professional development grants. Some grants are administered through universities or foundations.
	Pennsylvania Department of Education	4,998,000 (3 years)	
	Chicago Community Foundation	7,662,894 (4 years)	To support creation of 12 new small high schools in Chicago
	The Big Picture Company Providence, RI	4,110,000 (5 years)	To change how people think about high school education by modeling and building new small schools
	EdVisions Inc. Henderson, MN	4,430,000 (66 months)	To develop a minimum of 15 new schools over 5 years, create a network of these schools, and disseminate the successful practices of the New Country School and the network around the nation
Higher education	Gandhi Institute of Computer Education and Information Technology	5,000,000 (5 years)	To expand access to free computer education throughout India  (Mumbai, India)
	Harvard University  Cambridge, MA	3,600,000 (5 years) 250,000 (5 years)	To support the Change Leadership Group at Harvard Graduate School of Education. This May 2003 grant is for general operating support. Harvard also received 50,000 per year in at least other years: 2002, 2001, and 1999 for general support.
	Yale University New Haven, CT	1,000,000 (1 year)	To support a capital campaign for rebuilding the Yale University Art Gallery
	Duke University Durham, NC	35,000,000 (2 years)	To construct a new, multidisciplinary science facility. In May 2003, Duke also received a grant of \$125,000 over 5 years for general operating support
	Johns Hopkins University Baltimore, MD	40,000,000 (10 years)	To expand the Bill and Melinda Gates Institute for Population and Reproductive Health to strengthen leadership and institutions in developing
	Indiana University School of Medicine	998,800 (2 years)	To diminish the incidence of HIV in selected communities in Kenya through a comprehensive program
	Emory University Atlanta, GA	500,000 (1 year)	To improve the analytic capabilities of Epi Info (computer software)

Sector	Grantee	Amount \$	Purpose
	University of Manitoba Winnipeg, Manitoba	1,000,000 (2 years)	To support their program with the University of Nairobi to prevent the transmission of HIV/AIDS among commercial sex workers and their clients
	University of Montreal Montreal, Quebec	100,000 (6 months)	To support a population and health leadership center for French-speaking sub-Saharan Africa
	Makerere University Kampala, Uganda	3,507,340 (2 years)	To develop new prevention initiatives with the goal of reducing the risk of HIV transmission in the context of improved access to ARV therapies and treatments for opportunistic infections in an African setting
Pacific NW	The Seattle Foundation Seattle, WA	55,000,000 (11 years) 30,000,000	To provide matching funds to support health and social service organizations through the United Way of King County. This eleven year grant came a month after \$30,000,000 over one year for the same purpose.
	Fred Hutchinson Cancer Research Center Seattle, WA	2,500,000 (5 years)	To provide global health research pilot-project funding to non-governmental organizations in King County, Washington to attract new investigators, research and collaboration in the Puget Sound community
	YMCA of Greater Seattle	2,838,383 (5 years)	To expand the youth development and student achievement program to four Seattle Public Middle Schools
	Seattle Center Foundation Seattle, WA	2,000,000 (1 year)	To renovate the Seattle Center Opera House and construct the Marion Oliver McCaw Hall
	Emerald Height Academy Issaquah, WA	40,644 (1 year)	To purchase new computer equipment
	University of Washington Foundation	29,989,259 (4 years) 10,000,000 (10 years) 6,500,000 (1 year) 3,000,000 (1 year) 2,000,000 (1 year) 1,500,000 (5 years) 500,000	To facilitate a multi-site study in Africa to assess the efficacy of acyclovir treatment on the sexual transmission of HIV To establish the Mary Gates Scholarships to promote leadership and independence in education and community participation. To build a new Computer Science and Engineering Building  To establish the Bill and Melinda Gates Chairs in Computer Science  To support the Daniel J. Evans School of Public Affairs  To support cross-cultural training experiences and educational opportunities in global health To support the Campaign for the Student Athlete

Sector	Grantee	Amount \$	Purpose
	Reed College Portland, OR	1,000,000 (1 year)	To improve the campus library
	Whitman College Walla Walla, WA	1,000,000 (1 year)	To construct a new science library and renovate existing science facilities
	Seattle University	2,500,000 (1 year)	To support the development of a new student center
Media	Columbia University, Mailman School of Public Health NY, NY	488,200 (18 months)	To support a forum and broadcast production of a global health dialogue between Bill Gates and Bill Moyer on March 17, 2003 at the Mailman School of Public Health, New York
	WGBH Educational Foundation Boston, MA	6,000,000 (3 years)	To produce a television series on global public health
	National Public Radio Washington, DC	541,000	To support coverage and increase understanding of global health issues and crises. The first grant is dated February 21, 2000 for two years and the second one is dated July 30, 2002 for three years.
	KCTS Television Seattle, WA	807,800 11,000,000 (5 years)	To support the conversion to digital broadcasting
	Washington News Council Seattle, WA	225,000 (3 years)	To promote fairness, accuracy and balance within the Washington State news media. This 1999 grant follows a \$25,000 grant for 1 year made in 1998.
	Moxie Firecracker Films New York	1,000,000 (1 year)	To produce a two hour documentary examining the global AIDS crisis entitled "Within Reach: Hope for the Global AIDS Epidemic"
	National Press Foundation	104,000 (1 year)	To support educational programs for journalists as the XIV International AIDS Conference, July 2002
Other	Foundation Center New York	175,000 (1 year)	This annual grant was given in 2002, 2001, and 2000 for general support
	Brookings Institution Washington	1,000,000 (2 years)	To support a National Working Commission on Choice in K-12 Education
	Council on Foreign Relations New York	1,000,000 (5 years)	To fund a chair in Global Health Policy Studies to integrate health issues into US foreign policy
	National Center for State Courts	15,000 (1 year)	For general support given in 1995, 1996, 1997, 1998. In 2001, \$7,500 over one year given as "annual gift"

\*Source: Bill and Melinda Gates Foundation website, accessed September 7, 2003  
<http://www.gatesfoundation.org/Grants/default.htm?showYear=2003>

## Non-Innocence of the Expropriation of Health by Medicine

The third theme to be introduced in this chapter that will be revisited throughout the dissertation is the conflation of health with medicine or what Ivan Illich calls the “expropriation of health” (1976). As a solitary perspective, this conflation accounts for much of the conflict that underlies disparate views of health care reform as well as more fundamental assumptions about conditions that are needed to promote equitable and optimal health for all people in a given community.

A common way of understanding the history of medicine is as triumph:

The history of medicine in the fifty years since the end of the Second World War ranks as one of the most impressive epochs of human achievement. So dramatically successful has been the assault on disease that it is now almost impossible to imagine what life must have been like back in 1945, when death in childhood from polio, diphtheria and whooping cough were commonplace, when there were no drugs for tuberculosis, or schizophrenia, or rheumatoid arthritis, or indeed for virtually every disease the doctor encountered (Le Fanu 1999: xv).

Edward Golub has a similar framing of the history of biomedicine as he writes that so many people suffered and died untimely deaths prior to medical interventions that “we” cannot even imagine “the bleakness of the lot of the average person.”<sup>61</sup> The assumption is that it was action of physicians wielding new therapeutic weapons that made the “assault” on morbidity and mortality possible. This discursive framing is an instrumental use of health that privileges the ideologies and acolytes of biomedicine and capitalism.

Thomas McKeown makes a compelling argument that runs counter to the dominant gloss. He ascribes the propensity of medical historians to ascribe health improvements and rising populations to medicine as a “failure to distinguish clearly between the activities of the doctor and the outcome for the patient” (1988: 78). Since tuberculosis was first registered as a cause of death in 1838 in England and Wales, the death rate has fallen continuously, even prior to identification of the tubercle bacillus,

the use of chemotherapeutic agents such as streptomycin, and BCG vaccination. His explanations for improved mortality rates prior to effective treatment include increased resistance to infection due to improved nutrition and reduced exposure to pathogens due to improved living conditions.

This fits with the social production of health and disease theory: that “health and disease are products of the way society is organized, of the way subsistence is produced as well as surplus, and of the way subsistence and surplus are distributed among the members of society” (Turshen 1989: 24). Even more provocatively, this theory maintains that “mortality is nonspecific, that overall community health is not affected by the elimination of any one cause of death” (Turshen 1989: 24). Turshen cites the Inter-American Child Mortality Study findings that the eradication of measles by immunization made no change in overall child mortality, only in the specific cause of death (Puffer and Seranno 1973) as evidence of nonspecific mortality.<sup>62</sup> An important implication of the theory of nonspecific mortality is that it “shifts the question from what causes diseases to what causes ill health” (Turshen 1989: 26). Finding comprehensive ways to address what causes ill health is a radically different approach than the vertical disease approaches currently being advocated by the Gates Foundation<sup>63</sup> and other advocates of “global health science.”

Another deficiency in Le Fanu’s tale of the triumph of medical interventions is that it renders the everyday, constant presence of death that continues in much of the developing world completely invisible. High fertility rates and catastrophic infant mortality rates in Sub-Saharan Africa resulted in a life expectancy in 1990 of 52 years but a median age of death<sup>64</sup> of 5 years (World Bank 1993: 200). In plain language, that is unimaginable million and millions of dead babies and toddlers. The plight of Sub-Saharan Africa has only gotten worse since then as life expectancy at birth has dropped

from 52 years in 1990 to 48.7 years in 2000. Juxtapositions of the divergent life expectancies at birth and HDI between selected geographical regions are illustrated in

**Table 2.5 Comparison of Human Development Index, Life Expectancy at Birth, and Median Age of Death for Selected Geographical Regions, 1990, 2000**

Geographical Region	Human Development Index <sup>a</sup> 2000	Life Expectancy at birth in years <sup>a</sup> 2000	Life Expectancy at birth in years <sup>b</sup>	
			1990	Median Age at Death <sup>b</sup> 1990
<b>Sub-Saharan Africa</b>	0.471	48.7	52	5
Sierra Leone	0.275	38.9	38	2
Niger	0.277	45.2	38	3
<b>Burundi</b>	0.313	40.6	47	11
<b>Mozambique</b>	0.322	39.3	43	2
<b>Burkina Faso</b>	0.325	46.7	49	4
<b>Ethiopia</b>	0.327	43.9	48	4
<b>Chad</b>	0.365	45.7	47	7
<b>Central African Republic</b>	0.375	44.3	55	15
Mali	0.386	51.5	48	4
<b>Malawi</b>	0.400	40.0	47	4
<b>Rwanda</b>	0.403	40.2	44	3
<b>Angola</b>	0.403	45.2	46	3
Guinea	0.414	47.5	44	2
Benin	0.420	53.8	50	6
<b>Cote d'Ivoire</b>	0.428	47.8	57	10
Congo/ Zaire	0.431	51.3	49	6
<b>Zambia</b>	0.433	41.4	47	11
Tanzania	0.440	51.1	49	5
<b>Uganda</b>	0.444	44	47	4
Nigeria	0.462	51.7	49	7
<b>Togo</b>	0.493	51.8	54	7
<b>Sudan</b>	0.499	56	57	13
<b>Cameroon</b>	0.512	50	57	16
<b>Kenya</b>	0.513	50.8	59	15
<b>Zimbabwe</b>	0.551	42.9	62	26
<b>South Africa</b>	0.695	52.1	62	41
United States	0.939	77	76	76
Canada	0.940	78.8	77	76
Norway	0.942	78.5	77	78

Sources: a. United Nations Development Programme. 2002. Human Development Report 2002:

Deepening Democracy in a Fragmented World. New York: Oxford University Press, pp. 149-52.

b. World Bank. 1993. *World Development Report 1993: Investing in Health*. New York: Oxford University Press, pp. 200-201.

Table 2.5. Although it may be from HIV, tuberculosis, and diarrhea rather than polio and diphtheria, death is still very common, just a plane ride away, for children in 2004. As in England and Wales of 1838, it is alleviating poverty so that basic human needs are met that will most dramatically effect health. Medical care is important, but it constitutes only one of many factors that determine health.<sup>65</sup>

Conflating health outcomes with medical interventions provides a compelling rationale for pouring increasing proportions of society's fiscal and human resources into the "medical-industrial complex."<sup>66</sup> Growth of this industry in the United States may be traced by total health expenditures as a percent of GDP, which have increased from 5.1% in 1960 (OECD 2001) to 8.8% in 1980 to 13.2% in 2000 (CMMS 2002: Table 1). Projections are that national health expenditures will reach 17% of GDP, 2.8 trillion dollars, in 2011 (CMMS 2002: Table 1). Evans and Stoddart have made the point that the expansion of a health care system may have negative effects on health. The danger is a society that spends so much on medical care that it does not spend adequately on other health-enhancing activities may actually reduce the health of its population (1994: 55). The dominant discursive logic that more medical care will equal more health can actually result in less aggregate health within a community.

Evans and Stoddart are not endorsing Ivan Illich's more stringent argument<sup>67</sup> that less medical care would improve health because of clinical,<sup>68</sup> social, and cultural iatrogenesis. Illich unambiguously holds that the medical establishment is "a major threat to health" (Illich 1976: 3).<sup>69</sup> The "medicalization of society" or the "medicalization of everyday life" is a concern that Irving Zola (1978) shares with Illich. Medicine expands as an institution of social control as the warrant expands for what constitutes a "medical problem." A notorious historical example of medicalization for the purpose of social control may be found in the diagnosis of *drapetomania*. In 1851 Dr.

Samuel Cartwright of Louisiana described this “disease of the mind” among slaves whose “diagnostic symptom” was “absconding from service” (2001: 105).<sup>70</sup>

Alcoholism and drug addiction were once considered as human frailty, aging and pregnancy were once considered to be normal stages of life; now addiction medicine, gerontology, and obstetrics are board certified specialties. Professional expertise and technology have become ever more important in letting us know if we are okay. Deane Neubauer noted that individuals have become increasingly dependent on physicians and their diagnostic equipment to have their health status validated. “We come to see our “health” as defined by what the physician is able to tell us” (1984: 33).<sup>71</sup> This trend has only accelerated over the last two decades as “enhancement technologies” such as Viagra, Prozac, Botox injections, and sexual reassignment surgeries have increased the possibilities to be “better than well” and more authentically oneself through medical intervention (Elliott 2003).

### Typology of Selected Discursive Approaches to Health

Bryan Turner suggests that individual/secular concepts of health underpin the empiricist Cartesian approach of allopathic medicine. He contrasts this with collectivist and secular assumptions about health exemplified by social medicine. Turner notes that various paradigms can and do exist simultaneously:

...in Western societies there has been a long historical trend, starting with the scientific revolution in the late sixteenth and early seventeenth centuries, away from collectivist/sacred conceptions towards individualistic/profane perspectives, which simultaneously charts the rise of scientific professional medicine. However, this dominant paradigm is constantly challenged by both collectivist/secular social medicine and by alternative medical paradigms that draw upon various religious legacies (2000: 12).

Each paradigm assigns responsibility for health and its lack to different arenas depending on how causality is constructed. Paradigms articulate health “problems”



with preferred solutions in divergent ways. The logic of specific paradigms privileges institutions with resource allocations and leadership roles just as invested professionals and elites promulgate paradigms and institutions that are congenial to their Weltanschauung.

A provisional and fluid typology that suggests a continuum of active and additive discourses is outlined in the two sections (A and B) that comprise Exhibit 2.2.<sup>72</sup> Some of the distinctions between various discursive frameworks for “clinical medicine” (in the sense that it is orientated to the individual with a warrant to cure and care) may be viewed under the headings of sacred, complementary, biomedical, and medicalization. Various aspects of “social medicine” (in the sense that it is orientated to populations with a warrant to decrease incidence of diseases) are organized under the titles of traditional public health, new public health, social production of disease, and social production of health. Subsequent chapters in this dissertation will utilize this typology along with historical and current examples to illustrate how health is related to structural aspects of speakers who are situated within specific political, economic, and cultural spaces. Health is neither neutral nor innocent: investing health with particular meanings privileges some people and groups over others.

**Exhibit 2.2A**  
**TYPOLOGY OF SELECTED DISCURSIVE APPROACHES TO HEALTH**

	SACRED	COMPLEMENTARY	BIOMEDICAL	MEDICALIZATION
Warrants	cure, care, & console "high touch"	cure, care & console "high touch"	cure priority "high tech"	"expropriation of health by medicine" to cure & control iatrogenesis critique
Body as <sup>73</sup>	receptacle or "temple" for soul	site for internal & external harmony	well functioning machine	tool for production & consumption
Construction of health as	free from sin, evil	harmony of mind, body, and spirit	free from diseases caused by germs, genes, & behaviors	behavioral choices that support social norms
Surveillance Unit of analysis	Individual relational elements	Individual relational elements	individual outcomes segmented	social control of individual segmented
Locus of responsibility	individual grace	individual enlightenment	individual patient, client, or consumer	individual worker or citizen
Privileges	individual moral economy	individual harmony within interconnected universe	individual rights & responsibilities market	individual responsibilities market
Epistemology	supernatural  (mystery)	natural & supernatural  (mystery)	reductionist, empiricist, behaviorist (knowable)	reductionist, empiricist, behaviorist (knowable)
Methodological tools/practices	prayer, works revelation	body, mind, and spirit work	science & technology behavioral sciences	science & technology behavioral sciences
Role of state	legitimizes workers; may support with tax breaks & "faith-based initiatives"	history of contested legitimation & financial support subordinate to allopathic	legitimizes workers & sites by accreditation & funding; hegemonic typology for the state	social control by and for state supported by medicalization
Relationship to capital	unpredictable	commodified body source of capital	commodified body source of capital & facilitates capital	commodified body source of capital & facilitates capital

	SACRED	COMPLEMENTARY	BIOMEDICAL	MEDICALIZATION
Attitude toward change	transformation of individuals; affirming to variety of regimes	transformation of individuals; affirming to variety of regimes	transformation of individual; dominant regime affirming	transformation of individual; oppositional to dominant regime
Knowledge workers	clergy, faithful, Anointed	healers	scientific, medical, behavioral & financial elites	scientific, medical, behavioral, & financial elites
Locus of Administration	internal & external	internal & external	medical-industrial complex (international, federal & state agencies; clinic; academy; drug & med. technology industries)	internalized norms & external reinforcement (multiple sites of the helping professions)
Sample label & approach or intervention	"possessed"  exorcism	"cells running amok"  visualization exercises	multi-system organ failure high tech ICU response	Drapetomania, Attention-Deficit Disorder  slavery, Ritalin
HIV/ AIDS as	punishment suffering caused by disharmony with God's will	opportunity for healing	retroviral agent focus on biology & behavior	opportunity for increased surveillance of marginalized groups
Advocates	Christian Right	Project Inform National Center for Complementary and Alternative Medicine	AIDS Clinical Trials Group	Cindy Patton Stephanie Kane
Approach or intervention	abstinence-only sex education & "conversion" counseling	Massage, energy exercises, acupuncture, medicinal herbs	Highly active Antiretroviral therapy (HAART) trials	critique of problematic aspects of surveillance & social control

**Exhibit 2.2.B TYPOLOGY OF SELECTED DISCURSIVE APPROACHES TO HEALTH**

	TRADITIONAL PUBLIC HEALTH	NEW PUBLIC HEALTH	SOCIAL PRODUCTION OF DISEASE	SOCIAL PRODUCTION OF HEALTH
Warrants	decrease incidence of specific diseases	decrease incidence of specific diseases	decrease incidence of specific diseases	decrease incidence of nonspecific mortality
Body as	unit for work	unit for work	vulnerable unit for work	exploited unit for work
Construction of health as	free from diseases	managing risk	mitigated effects of harmful environment	WHO definition
Surveillance Unit of Analysis	population relational	individual & population focus on individual	population relational	population relational
Locus of Responsibility	state	individual	state, capital, individual	neoliberal regimes in capitalist states
Privileges	rights & responsibilities polis & market	individual responsibilities market & polis	private & public goods market & polis	public goods polis
Epistemology	reductionist, empiricist, behaviorist & pragmatic (knowable)	reductionist, empiricist, behaviorist (knowable)	multifactoral heuristic (knowing problematic due to complexity)	political economy heuristic (knowing problematic due to complexity)
Methodological Tools or Practices	social medicine, analysis of infrastructure, statistics, epidemiology	social science and behavioral research, health promotion & education	Reform versions of social epidemiology & population health, occupational & environmental health, liberal critique of "health determinants"	Radical versions of social epidemiology & population health, Marxist political economic critique of "health determinants"
Role of state	surveillance mobilizes intervention and control	surveillance reduced central control & financial support	surveillance regulatory role contested	surveillance state implicated in production of health

	TRADITIONAL PUBLIC HEALTH	NEW PUBLIC HEALTH	SOCIAL PRODUCTION OF DISEASE	SOCIAL PRODUCTION OF HEALTH
Relationship of capital	facilitates capital by enabling healthy workers	sustains regimes but potentially conflicting (what if you thwart capital by non-consumption?)	ambivalent--capital as source of health and implicated in disease production	conflicts with neoliberal ideology of dominant culture in postindustrial states
Attitude toward Change	what begins as radical ideology becomes institutionalized; dynamic	targets radical change at individuals while affirming regimes	paralysis by ambivalence and ambiguity supports regimes	radical changes at every level, regime challenging
Knowledge workers	social reformers, sanitation & technical experts, statisticians, epidemiologists,	social science researchers, behavioral health, health promotion educators, risk analysts	reformist scientific, medical, labor, consumer elites	marginalized elites and oppressed masses
Locus of Administration	international, national, & local institutions such as WHO, federal & state & county health departments	Directed to individuals through primary care & to groups through social marketing. Programs include "Healthy People," "Healthy Cities" and Workplace Wellness"	international, national, & local institutions such as ILO, OSHA, labor unions, citizen groups	idealized, radical forms of primary health care and population health
Sample Label & Approach	"miasma" infrastructure changes	"inappropriate lifestyle choices" education	"black lung" transition from company doctors to labor rights	"nonspecific mortality" interrogate hierarchies including capitalism
HIV/AIDS as Approach	Mysterious disease disproportionately affecting gay men initially called Gay-Related Immune Deficiency (GRID) CDC, 1981, used contact tracing, and mapping of disease	Result of ignorance of risky behavior, unwise "lifestyle choices," and inability or unwillingness to control desires" "Just Say No" drug & sex education programs to Harm Reduction Coalitions advocating needle exchange.	Mental health issues linked to homophobia & despair leading to high risk behavior Human rights & cultural competency program	Poverty is the root cause of AIDS. Inequities of every kind produce disease and make HIV "just another way to die." Partners in Health address structural violence & do clinics.

In particular, a repetitive refrain throughout this dissertation is a lament that the relentless aggrandization of medicine extinguishes competing discourses about health. This will be discussed in a variety of contexts in the United States and Canada in ensuing chapters. Bill Gates is emblematic of naturalized success in the New Economy and within entrepreneurial global health science regimes. Web sites calculate how much he makes per second, business schools use him as a case study, and his very name has become synonymous with “as rich as.” An aggrandization of Bill Gates conflated with a glorification of individualism might be viewed in a lesson plan posted on the NOW With Bill Moyers website<sup>74</sup> directed to high school teachers preparing a global health unit. As a way for students to “get a deeper understanding of global health issues by examining the philanthropic efforts of Bill Gates,” students are encouraged to discuss “what they would do with their money if they were billionaires.” In addition to encouraging students to know “who Bill Gates is,” the lesson plan concludes with the culminating activity of writing a grant proposal. In this particular framing of “global health issues” there are no competing discourses to ask if a vibrant, socially just political economy could be organized without billionaires or if health care could be rights-based rather than charity-driven. As an alternative to Bill Gates naturalized success formula, we will conclude this chapter with a brief consideration of Rudolf Virchow (1821-1902). Virchow could be designated as an “anti-poster child”<sup>75</sup> to draw together this chapter’s themes of monotheism, liberalism, and the appropriation of health by medicine while setting the mood for historical perspectives to be explored within Chapter Three.

Moving within the biomedical typology, Rudolf Virchow is perhaps best known for establishing the relationship of cells to the pathology of tissues (Golub 1997: 144). He demonstrated the nature of leukemia, coined the term “emboli” in his study of phlebitis, was the director of the first independent pathological institute, and was even called “the pope of German medicine” (Shryock 1936: 203-205). Moving to the social production of

health typology, Virchow is the author of “one of the neglected classics of ‘social medicine,’ a term he did much to popularize” (Taylor and Rieger 1985: 547).

As an “outside expert” at the age of 26 years, Virchow was appointed by the government to study a typhus epidemic that broke out in Upper Silesia at the same time as a famine in the winter of 1847-1848. In his report, Virchow starts with a detailed geographical, anthropological, and sociological account of the area including caste-like stratification associated with occupation and nationality, role of the Catholic Church, housing conditions, diet and drinking patterns, and popular healing beliefs and practices of the people. He then discusses infectious diseases that are caused by bacteria but which spread by increased vulnerability due to inadequate housing, working, food, and sanitation conditions. Virchow gives a detailed clinical account of typhus along with differential diagnosis, case descriptions, and autopsy reports. He does an evaluation of the accuracy and validity of available statistics in what has been described as a “sophisticated epidemiological section.”<sup>76</sup> His short-term recommendations include a reorganized food supply, a notification system for case reporting, and an inter-agency council representing various sectors of the community. Competent and perhaps even brilliant in his capacity to utilize the tools of the biomedical and traditional public health paradigms though he was, it is his long-term recommendations that give pause: unlimited democracy, universal education, increased employment, better wages, disestablishment of the church, devolution of decision making, progressive taxation reform, agricultural improvements and cooperatives, and industrial development (Taylor and Rieger 1985) (Waitzkin 1981). Going way upstream, Virchow argued that economic insecurity and political disenfranchisement cause disease and death through a complex web of causality. Virchow’s report concludes: “In the final analysis every individual has the right to existence and health, and the state is responsible for ensuring this” (Taylor and Rieger 1985: 554).

Concerns about Virchow's "radical political tendencies" of 1848 threatened his career in academic medicine and he was suspended from his position in Berlin in 1849<sup>77</sup>. Virchow had to publish his report in his own journal and it was completely ignored by the Prussian government. Taylor and Rieger point out that while the "social origins of illness are no longer disputed, yet 130 years after the publication of Virchow's Report, governments are still unwilling to accept the corollary, that is, that socioeconomic improvements are more necessary than medical ones" (1985: 557).

Virchow is a fascinating exemplar of polytheism in science in that his investigation into the famine and typhus epidemic in Upper Silesia described multiple, intertwining causal pathways while critiquing religious monotheism and the interests of capital. He could have knocked off a bacteriological treatise on typhus and been valorized for his scientific acumen as a medical professional. He could have written an apolitical prescription for sanitary reforms and been lauded for his skills as a sanitarian. Either of those approaches would probably have qualified him for a grant from the Bill and Melinda Gates Foundation. Instead, he integrated both of those perspectives while extending his diagnosis<sup>78</sup> to a political, social, economic situation in need of amelioration by transformations that would challenge established regimes of power. His meticulous work was essentially invisible at the time except to the extent that he was denigrated as a radical because of it. In 2004 it is probably fair to say that more people puzzle over his aphorism arising from this study of famine and typhus in Upper Silesia than appreciate its explanatory context:

Medicine is a social science, and politics nothing but medicine on a grand scale.  
Rudolf Virchow<sup>79</sup>



CHAPTER THREE  
"SCIENCE AT THE PROW AND COMMERCE AT THE HELM:"<sup>80</sup> A NARRATIVE OF  
PROFESSIONALIZATION AND ENTREPRENEURIALIZATION OF HEALTH BY  
MEDICINE

The overarching purpose of this chapter is to provide historical and social context that might illustrate and illuminate inexorably linked themes of the growth of medicine as a profession and as an entrepreneurial endeavor. To this end, three timelines of selected historical events outside of North America (Exhibit 3.1), in the United States (Exhibit 3.2), and in Canada (Exhibit 3.3) will be presented. The second section of this chapter will explore the dominant discursive history of organized medicine by juxtaposing the tale of Great Men doing Great Deeds with self-interested guild activities such as witch burning, midwife bashing, and quack hunting. The third section of this chapter will discuss the growth of biomedicine as a legitimating discourse as an integral aspect of the professionalization of medicine from Abraham Flexner's work funded by robber baron philanthropists to a doubling in the National Institutes of Health's budget from 1998 to 2003. The last section of this chapter examines instances of the protection of entrepreneurial medicine by organized medicine as evinced by stands of the American Medical Association against "socialized medicine" and by Canadian physicians who went on strike to protest universal health insurance in the province of Saskatchewan in 1962. This chapter provides additional exemplars of the discursive frameworks of monotheism and liberalism discussed in Chapter Two as it continues the argument that the non-innocent appropriation of health by medicine has predictable consequences.

There are elements in the study of professions, especially of medicine, which are characteristic and well studied. This dissertation wishes to build on but not repeat this literature. There is a robust and growing literature, for example, which is focused on racism, classism, and sexism in constructions of social life and in the professions. Nancy

Krieger makes a compelling argument that social constructs, such as discrimination and inequity, harm health through a variety of pathways (2000). Situated within specific historical and cultural contexts, the profession of medicine is not immune to normative views of gender, race/ ethnicity, sexual orientation, or class commonly held by dominant cultures as studies of privilege in the medical academy have indicated (Eisenberg 1989) (Wear 1997). This is not a new argument nor is the problematic unique to the profession of medicine. Even so, it is worthwhile to observe rhetorical glosses that have been used and continue to be used by organized medicine to justify self-interested actions as moral, natural, scientific, or for the good of others.

While the broad sweep of a timeline may be useful for sketching parallel trends in disparate geographical spaces and discontinuities over time, such parsimonious treatments entail a loss of detail that might jar current expectations. As an illustration of some of the back-story not apparent from the timelines, we might imagine that from the point of view of a patient it was arguably preferable to be a patient in Quebec's Hôtel-Dieu Hospital in 1690 than in the Pennsylvania Hospital or Montreal General Hospital in 1850. The Hôtel-Dieu Hospital was run by religious sisters for the military as "a model of cleanliness, with curtains on the beds, separate rooms for the severely ill, and daily visits by an attending physician and surgeon" (Gelfand 1987: 87). For the period 1689 to 1698, mortality was only slightly over 7 percent on average (although deaths could rise dramatically to as high as 25 percent of admissions during epidemics) so that the Hôtel-Dieu of Quebec did not have the dreaded reputation of the Hôtel-Dieu in Paris, where over 20 percent perished (Gelfand 1987: 89).

This might be contrasted with Philadelphia's Pennsylvania Hospital, where mortality rates for surgical procedures were increasing probably due to infection. For example, "during the decade 1850-1860, death rates in amputations were 241.23 in a

thousand—and an even more alarming 266.89 in the next ten-year period” (Rosenberg 1987: 122). Rosenberg notes that

...a poor woman was safer with a midwife or private practitioner in her own home, no matter how deprived, than in the best staffed and endowed of hospitals. The direct relationship between the scale of a hospital’s size and prestige and its mortality rates seem particularly unsettling, for the larger metropolitan hospitals enjoyed the services of the most eminent surgeons on their attending staffs (1987: 123).

Patients had to fight rats for their food at the Montreal General Hospital when William Osler was a medical student there (Bliss 1999: 61). *Harper’s Weekly* featured a prebellum hospital scene of a woman being overrun in her bed by rats at Bellevue Hospital in New York City (Rosenberg 1987).

While much of the differential in experiences may be attributed to a regime of benign palliation in a provincial setting in Quebec compared with invasive therapeutic regimes in the later urban settings,<sup>81</sup> part of this story also rests with orientations to the social standings of patients. People of property and status tended to avoid hospitals unless they were “stricken with insanity or felled by epidemic or accident in a strange city” (Rosenberg 1987: 4). Within America’s first hospitals there was an emphasis placed on making distinctions between the “worthy and unworthy poor.” In the late eighteenth century the Pennsylvania Hospital “demanded a written testimonial from a “respectable” person attesting to the moral worth of an applicant before he or she could be admitted to a bed” (Rosenberg 1987: 19). At the Hôtel-Dieu soldiers and sailors had priority over civilian patients, but the military occupied only a little more than 20% of the 5,000 admissions in the years 1689 to 1698 (Gelfand 1987: 87). In contrast to France at that time or later urban North American hospitals, even well-to-do persons availed themselves of the hospital:<sup>82</sup> “it is customary in this country for everybody to let themselves be taken there when sick—the powerful, the rich, and all the clergy—and this is because there is easy access to the doctor and to appropriate remedies and

because of the special attention given to patients by the nursing sisters”(Gelfand 1987: 87). This might be seen as an early instance of the logic of universal access to medical services increasing quality of care or at least diminishing altercations with scrappy rodents.

Acknowledging a loss of nuance inherent in timelines, the arguable significance of events that were arbitrarily chosen compared with those events that remain invisible, and the overall folly of sweeping through centuries to capture hints of historical spoor, Exhibits 3.1, 3.2, and 3.3 are still worthy of consideration. A few trends to note within these tables are as follows. From the Great Plague of Athens following the Peloponnesian War to New World genocide of indigenous peoples to the influenza pandemic accompanying troops home from World War I, global flows of germs have marched with soldiers, traders, and missionaries seeking material and spiritual booty. A long-standing tradition of considering the body as valuable property or as a commodity can be traced from Galen’s job as a physician to look after gladiators to episodes of murder, extortion, and theft to obtain corpses for dissection to rationalizations for the American slave trade to the most common reason for proprietary kidney “donation” in 1999 in developing countries being to provide food for the donor’s family. Physicians are products and producers of their cultures especially with respect to political economic factors such urbanization, technological imperatives, organization of labor, and relationship to capital. Health issues and medical services in Canada and the United States have complementary and diverging trajectories but they are always enfolding with each nation observing the other. Germs, capital, labor, and cultural products flow back and forth across the world’s longest contiguous international border and co-mingled mediascape<sup>83</sup>.

**Exhibit 3.1 Timeline of Selected Historical Events Outside of Canada and the United States\***

<b>Date</b>	<b>Selected Historical Event Outside of Canada and the USA</b>
600,000 B.C.E.	<i>Homo sapiens</i> using fire. First humans, as hunters and gatherers, live in balance with pathogens until times of ecological imbalance.
prehistory	Archeological evidence found in Europe, the Pacific, and Peru give examples of early surgical interventions that were successful. Hundreds of skulls with neatly healed bone growth suggest people survive after holes are cut in their skulls (trephining).
437 B.C.E.	Hippocrates perhaps dies (if he actually lived). He separates medicine from religion and philosophy.
431 B.C.E.	Great plague of Athens follows Peloponnesian War
300 B.C.E.	Anatomy and physiology develop in Alexandria
100s C.E.	Asclepiades brings Greek medicine to Rome. Ancient medicine culminates with Galen (129-99 C.E.), who unites Hippocratic teachings with anatomical and physiological observations. Galen's first job as a physician is to look after valuable property, gladiators.
200s	Growing Christian religion emphasizes healing by faith
400s	Fabiola founds first hospital in Western world in Rome
533	Justinian Code reminds public officers of their duty "to choose to do honest service for the poorest rather than be disgracefully subservient to the rich." During Roman times, public physicians (archiatri) are employed by the state to care for the poor as they also engage in private consultations for paying patients.
542	Plague of Justinian, first pandemic, decimates from Asia to Ireland
700s	Arabs develop pharmacology as a science separate from medicine
750	Polynesian people migrate from Tahiti to Hawai'i
800s	Monk physicians treat the sick in infirmaries attached to monasteries
900s	Influential medical school founded in Salerno, Italy—women are included as students.
931	Examining and licensing board for healers established in Baghdad
1000s	Arab physician Avicenna writes textbook, <i>Canon</i> , used in medieval Europe.
1100-1700	Many thousands killed as witches in Europe. Crime of many witches is to have magical healing powers.
1123-1125	St. Bartholomew's Hospital and St. Thomas's Hospital founded in London, partly to care for returning Crusaders.
1150-1400	Guilds become the main way of organizing work in many European towns.
1200s	Thomas Aquinas describes medicine as an art, a science, and a virtue.
1229	University scholars leave Paris for Oxford and Cambridge in protest of the failure of local government and Church to support scholars' guild.
1348	"Black Death" or plague arrives in Europe. It eventually kills at least one-third of Europe's population. Jewish people suffer as scapegoats.

Date	Selected Historical Event Outside of Canada and the USA
1510	Parliament of England authorized bishops to examine and license physicians and surgeons. Graduates of Oxford and Cambridge can practice without episcopal approval with license from university faculties.
1518	The British Crown gives the Royal College of Physicians examining and licensing powers for self-regulation. Similar privileges are given to London Company of Barber-Surgeons in 1540 and London Society of Apothecaries in 1617. Within medical hierarchy, physicians are on top.
1543	Andreas Vesalius publishes book on human anatomy
1596-1650	Rene Descartes born. Cartesian materialism and secularism along with dualism (that separates mind and body) furthers individualistic, rational, and experimental scientific Renaissance.
1606-1608	The Globe, Shakespeare's theater, closes for almost 30 of 36 months during this time period due to plague in London from 1603 to 1613
1623-1687	William Petty, "father of political arithmetic," born. As physician, economist, and scientist, he is interested in a healthy population for a powerful state.
1628	William Harvey publishes on circulation of the blood
1629	Smallpox first listed as separate disease in London. By 1700 it is a leading cause of death in England.
1676	Anthony van Leeuwenhook invents the microscope and describes "little animals" (bacilli, spirilla, and cocci)
1696	First workhouse in England is established in Bristol as "center of manufacture" where the "poor could learn to support themselves."
Late 1700s	More than 80% of all people live in rural areas
1764	Wolfgang Thomas Rau (1721-1772) of Germany first uses term "medical police"
1778	Life expectancy higher in Hawai'i than in Europe due to good nutrition and sanitation as well as beneficial effects of isolation from contagious diseases. Paleopathological studies show "astonishing" bone setting skills. Captain James Cook arrives in 1778 and missionaries land in 1820. Population decimated from 800,000 to 40,000 in the early 1890s.
1793-1794	Following the Declaration of the Rights of Man, France passes a series of laws to establish a national system of social assistance, including medical care. Guilds for medicine and surgery abolished in favor of two-class system: doctors and surgeons and lesser-trained health officers. Historians also credit French Revolution as sparking the start of "hospital medicine" to replace "bedside medicine."
1798	Edward Jenner publishes pamphlet on smallpox vaccination
1798	Thomas Malthus publishes <i>Essay on Population</i> , which argued disease is nature's "terrible corrective" to overpopulation. He also advises against providing relief to the poor as it would only discourage them from work.
1800	Humphrey Davy experiments with nitrous oxide in Bristol.
1802	Health and Morals of Apprentices Act limits work of children in factories to 12 hours per day but sets new lower age limit in England.
1819	Rene Laennec invents the stethoscope

Date	Selected Historical Event Outside of Canada and the USA
1825-1845	Sporadic experiments with ether and chloroform occur in Europe. In 1884 Sigmund Freud and Carl Koller introduce cocaine as local anesthetic.
1832	British Parliament passes its first "anatomy act" after series of murders in Edinburgh to procure "subjects" for dissection.
1833	England's Factory Act sets minimum age of work in textile factories to 9
1839	"Great Hunger" of the Irish potato famine causes massive emigration
1840	Louis René Villermé publishes <i>Tableau de l'état physique et moral des ouvriers employés dans les manufactures de coton, de laine et de soie</i> . French sanitarians collect health statistics that document health inequities between rich and poor. They situate problem as one of political economy rather than engineering. "Death is a social disease."
1842	Edwin Chadwick presents his <i>Report on the Sanitary Condition of the Labouring Population of Great Britain</i> to the House of Lords. Weaker version of recommendations becomes Public Health Act of 1848. Chadwick said to be "one of the most hated men in England" for designing the New Poor Laws (1832-1834) so all relief outside of workhouse was unlawful.
1847-1848	Typhus epidemic occurs in Upper Silesia. Government appoints Rudolf Virchow to study situation. Virchow had to publish report in his own journal in 1849 and results were ignored by Prussian government. He is famous for establishing relationship of cells to the pathology of tissues thus facilitating new era of "laboratory medicine."
1848	Henry Hanock of London first removes an appendix.
1851	First International Sanitary Conference, Paris follows the first (1828-1831) and second (1847) cholera pandemics. Twelve states participate to discuss concealment of cholera outbreaks by many countries and fraudulent bills of health of ships. Convention ratified by 3, of which 2 later withdraw.
1852	Prussia requires uniform educational standards. Other German principalities soon follow with new laws requiring the same state examinations and licenses for all physicians.
1854	John Snow removes handle from Broad Street pump. Snow was ignored at his time but is considered a public health hero today. Germany's Max von Pettenkofer ensured Munich had safe drinking water but as his action was based on miasma theory, he is often derided today.
1858	Medical Act of 1858 in Britain sets up a National Registry of regular practitioners, who are given rights to sue for fees and enter government service. This Registry was maintained by a Council for Medical Education responsible to the Privy Council.
1859	Charles Darwin publishes <i>Origin of Species by Natural Selection</i> .
1860	Vatican declares that midwifery is "incompatible with the vow of chastity" so women religious hire physicians or lay midwives to assist those in their care.
1866	Gregor Mendel publishes experimental results on genetics which are basically unread until discovered by three separate investigators in 1900
1868	Hawaiian Board of Health is appointed to examine and license kanaka maoli healers, with the requirement that records be kept. These laws are repealed in 1893 when Queen Lili'uokalani is overthrown by U.S. capital and troops.

Date	Selected Historical Event Outside of Canada and the USA
1875	Robert Koch completes work showing specific bacteria cause anthrax. He announces cure for tuberculosis in 1890 which disappoints but tuberculin does prove valuable as diagnostic tool.
1880s	Otto von Bismarck introduces first state health insurance plan in Germany as a means to strengthen the state and provide a "welfare monarchy" to assure loyalty of the workers.
1891	Hungary adopts universal health insurance legislation.
1892	The <i>loi le Chapelier</i> is repealed and doctors in France set up a national medical association and a bargaining association.
1895	Louis Pasteur dies. Pasteur's discovery that specific organisms cause specific kinds of fermentation sets stage for germ theory that specific organism cause specific diseases. Pasteur becomes "symbol of science" and is given credit for many of the advances brought about by sanitarians.
1895	Physicist Wilhelm Roentgen discovers X-rays.
1900	Paul Ehrlich addresses Royal Society of London setting intellectual basis for specificity of reactions of the body and chemically specific therapy, which he calls "magic bullets."
1900-1911	Private practitioners in Germany organize against sickness funds by setting up unions, boycotts, and strikes. By 1913, the government has to broker a treaty between the sickness funds and the medical profession.
1910	State regulated professional monopoly in Italy takes the form of <i>ordini</i> for doctors, which has licensing functions.
1911-1939	Lloyd George and Liberal Party in Britain pass national health insurance for poorer members of society, which expands to 75% of population having at least partial coverage by 1939.
1923	Health Organization of the League of Nations is established.
1929-1930	Confederation des syndicats medicaux francais (CSMF), the major French doctors' bargaining union, successfully blocks implementation of national medical system.
1939	Natural Healers Law gives allopathic medicine monopoly over "natural medicine" in Germany. Nazis undermine the social insurance system of the Weimar period. German doctors are complicit with forcing socialist and Jewish doctors out of practice during episode of high unemployment for physicians.
1940s	Use of antibiotics becomes widespread with invention of salvarsan, sulfonamide, penicillin, streptomycin, and chloramphenicol.
1942	Beveridge report, commissioned by Churchill government, calls for "social security from the cradle to the grave," full employment, and provision of a national health service for everyone.
1946	Transfer of functions and staff from League of Nations to the World Health Organization of the United Nations. WHO Constitution describes health as one of the "fundamental rights of every human being."
1946	Britain passes the National Health Act. National Health Service starts in 1948. The British Medical Association called for a strike just before NHS is to go into effect but the majority of members rebel against British Medical Association to support NHS.



Date	Selected Historical Event Outside of Canada and the USA
1952	Intensive care and artificial ventilation pioneers in Copenhagen during polio epidemic. Neonatal intensive care starts in 1970.
1956	Dr. Ian Donald first uses ultrasound as diagnostic tool in the practice of obstetrics and gynecology at the University of Glasgow.
1958-1960	DeGaulle reorganizes the French health insurance and hospital systems.
1963	Immuno-suppression drug, Azathioprine, fosters successful kidney transplant. By 1999, the most common reason worldwide for donating a kidney is to feed the family.
1967	First clinical use of Magnetic Resonance Imaging takes place at Nottingham University Hospital in England.
1972	Godfrey Housfield invents Computerized Tomography Scan in England
1973	American supported coup kills Salvador Allende in Chile. As a democratically elected, socialist physician president, Allende refuses to discuss specific health problems apart from macro-level economic and political issues. The Chilean Medical Association (Colegio Medico) was implicated in support of Allende's overthrow and human rights violations.
1977	British government appoints Research Working Group to explore health inequities. In 1980 they submit <i>Black Report</i> documenting poorer health of lower classes across all stages of life caused by factors outside NHS. Only few copies are made available and reception is "frosty."
1977	Thirtieth World Health Assembly adopts resolution WHA30.43 of "health for all by the year 2000" as mechanism for advocating health as fundamental human right.
1978	Alma-Ata International Conference on Primary Health Care introduces primary health care a comprehensive strategy for of achieving "health for all." It involves economic and social development of communities as well as health care delivery.
1978	Italian National Health Service is created as cost-control measure after the entire system of private insurance goes bankrupt. Doctors are split between elite 15% specialists attached to teaching hospitals and the rest, with one of the highest doctor-patient ratios in the world. Doctors are said to experience more solidarity and unity after passage of this law as they mobilize against the state's attempts to nationalize and rationalize.
1978	Louise Joy Brown, first "test-tube" baby born in England
1979-1990	Term of office for the United Kingdom's first female Prime Minister, Margaret Thatcher. The "Thatcher Revolution" or "Thatcherism" was an ideologically driven program of deregulation, privatization, devolving public sector and trade union reforms.
1983	An estimated 90% of Israel's physicians go on strike for 118 days for a wage dispute with no changes in mortality.
1986	Update of <i>Black Report</i> is commissioned in the United Kingdom, which causes controversy upon release in 1987 as <i>The Health Divide</i> .
1992	Richard Wilkinson's essay on "Income Distribution and Life Expectancy" in the <i>British Medical Journal</i> sparks cascade of new research and debate on social determinants of health.

Date	Selected Historical Event Outside of Canada and the USA
1993	International health leadership shifts from World Health Organization to World Bank with World Bank's publication of the <i>World Development Report 1993: Investing in Health</i> . By 1997 The World Bank becomes the "biggest public health care funder" in the world by funding \$13.5 billion worth of projects (Garrett 2000: 9).
2002	Number of global deaths attributable to HIV / AIDS in 2002 is 3.1 million; number of new HIV infections globally this year is 5 million; estimated number of people living with HIV worldwide is 42 million.

\*Sources: (Basch 1990; Black et al. 1992; Buse and Gwin 1998; Chadwick 1965; Chun 1994; Clarke 2000; Coleman 1982; Ehrenreich and English 1973; Freidson 1988; Fuchs 1961; Garrett 2000; Golub 1997; Hamlin 1998; Kawachi, Kennedy, and Wilkinson 1999; Krause 1996; Le Fanu 1999; McKeown 1988; Mitchinson 1991; Rosen 1958; Savoie 1994; Scheper-Hughes 2002; Shryock 1936, 1967; Slater and Ever-Hadani 1983; Stannard 1989; Starr 1982; Taylor and Rieger 1985; Turner 2000; UNAIDS/WHO 2002; Waitzkin 1981; Whitehead 1992).

**Exhibit 3.2 Timeline of Selected Historical Events in the United States\***

Date	Selected Historical Event in the United States
18,000-10,000 B.C.E.	Aboriginal peoples migrate to North America. North American aboriginals familiar with foxglove ( <i>digitalis</i> ), laxative, diuretic, emetic, and antipyretic substances.
1539 C. E.	Pueblo Indians in New Mexico first encounter Europeans. Population drops from at least 130,000 to only 6,440 in 1706 due to violence and disease.
1607	Virginia Company establishes settlement at Jamestown, Virginia. Many of earliest practitioners of medicine in New England are clergy.
1619	First African slaves arrive and are sold in Jamestown, Virginia
1636	Harvard College founded in Cambridge, Massachusetts. Harvard Medical School opens in 1783.
1638	Plymouth Colony passes law to prohibit "oppressing" buyers "when their necessities do constrain them to buy at any price." Next year, Virginia allows appeals against physicians who extort in pricing.
1640s	New England colonies of Plymouth, Rhode Island, Massachusetts, Connecticut, New Haven, and New Hampshire enact laws making witchcraft a capital offense.
1649	Massachusetts passes law to correct abuses of chirurgions, midwives, and physicians. This law is framed as encouragement to do right rather than prohibiting against practice.
1701	Many Europeans dissatisfied with current medical practices of bleeding, purging, and poisons are impressed with healing practices of aboriginal peoples. Englishman John Lawson reports that cures performed by Indians are "too many to repeat" as they display "extraordinary Skill and Success"
1721	Boston's smallpox epidemic serves as stimuli for creation of Club of Physicians to oppose inoculation without quarantine
1750	America's "first wave of professionalization" brought back as physicians studying medicine in European cities return to USA.
1751	Foundation of Pennsylvania Hospital in Philadelphia
1760s	Smallpox decimates Ottawa tribe of Michigan. The British deliberately infect them because of their friendly relationship with the French.
1760	New York regulates practice of medicine by requiring examinations of physicians and surgeons. In trials of unlicensed practitioners in 1837, the accused almost always had sympathy of the public.
1763	Request by physicians to Connecticut legislature to found society with licensing power rejected
1765	Charter of first medical school, College of Philadelphia. The first two medical professors, John Morgan and William Shippen, fight so bitterly they divide the school and the Continental Army.
1763	William Shippen is first physician in colonies to set up obstetrical practice; this signals shift from midwives to doctors among women in urban middle class.

Date	Selected Historical Event in the United States
1766	First provincial medical association organizes in New Jersey. Of the first 100 members of the Medical Society of New Jersey, 4 medical practitioners sign the Declaration of Independence and 17 become members of Congress or the state legislature.
1771	The Spunkers and Club of Generous Undertakers, student medical societies at Harvard College, are established for body snatching.
1776	The year that Declaration of Independence is signed there are 3,500-4,000 physicians; of these perhaps 400 had formal medical training, 200 with medical degrees.
1789	First session of Congress meets. George Washington inaugurated.
1790	5,000 physicians; one doctor per 950 people
1791	Although organized in 1771, the New York Hospital starts receiving patients in 1791.
1793	First local health department with a permanent board of health formed in Baltimore, Maryland.
1798	Marine Hospital Service established to care for merchant seamen. The Treasury Department collects twenty cents per month from the wages of each seaman to cover costs of a series of contract hospitals.
1800-1830	These decades signal the break with classical medicine and formation of modern clinical methods. Therapeutic skepticism abounds as early empirical investigations show accepted techniques are ineffective.
1809	Samuel Thompson, founder of botanic medicine, is acquitted of doctor-generated accusation of murder of a patient. Thomsonian movement's sympathies were "with the laboring classes, to overthrow this tyranny of priests, lawyers, and doctors" while seeking patent protections.
1811	Ohio introduces medical Licensing which is repealed in 1833
1817	Illinois empowers medical societies to issue licenses but abolishes licensing in 1826.
1820s	State legislatures enact licensing laws and then begin to rescind them as they are seem to be a marker of favor rather than competence.
1830-1840	Collapse of medical licensing
1843	Dr. Oliver Wendell Holmes suggests that puerperal fever is being transmitted by the unclean hands of doctor moving among patients.
1846	Dentist, W. Morton, demonstrates ether for surgery at Massachusetts General Hospital.
1847	American Medical Association (AMA) founded
1848	New England Medical College, founded in Boston, first medical school exclusively for women in the world
1850	40,000 physicians; one doctor per 600 people. Doctors complain of overcrowding in profession. Doctors are well distributed rurally.
1850	Medical schools proliferate after War of 1812. By 1850 there are 42 schools in USA compared with 3 in France.
1851	AMA study of graduates between 1800-1850 from 8 leading colleges finds that fewer than 8% became physicians compared with 26% each who became clergy or lawyers indicating "general distaste for medicine among the educated talent of the country."

Date	Selected Historical Event in the United States
1856	Eclectic Medical Institute of Cincinnati site of dispute among professors and allies where knives, pistols, chisels, blunderbusses, and a six-pound cannon are displayed as part of discourse.
1862	Entire student body from Winchester Medical College in Virginia loot three bodies from John Brown's raid on Harpers Ferry. One was John Brown's son, Owen. Federal army recovers body and college buildings of this proprietary school are burned to the ground.
1868	The hospital department of the Southern Pacific Railroad Company organizes the first major industrial prepayment program.
1870-1910	Number of physicians per 100,000 grows from 171 to 241 in large cities, and falls from 160 to 152 in the rest of the country. Doctors move to cities even more rapidly than urbanizing population.
1870s	Committee of the AMA recommends that the Massachusetts Medical Society lose representation until it purges itself of heretics. Facing court battle, homeopaths are expelled.
1871	American Public Health Association established
1877	First telephone exchange connects drugstore with 21 doctors in Hartford
1879	Congress creates National Board of Health in response to impending yellow fever epidemic
1880	Medical schools: 76 for regulars, 14 for homeopaths, 8 for Eclectics, and 2 for "physiomedicals" descendants of Thomsonians.
1880s	African American woman murdered and sold to the University of Maryland Medical School for fifteen dollars.
1882	State medical society of New York votes to abolish the clause in ethical code that forbids consultations with sectarians. Society is expelled from AMA and new New York Medical Association was formed to replace it as state's national representative.
1886	Association of American Physicians founded by "more scientifically minded members" of AMA seeking an association "in which there will be no medical politics and no medical ethics"
1887	One room laboratory within the Marine Hospital Service, predecessor agency to the U.S. Public Health Service, is antecedent to NIH.
1889	Kansas passes first general legislation regulating trust which specifically includes prohibitions against price fixing by doctors and lawyers
1889-1903	Every week, on average, two African-Americans are lynched by mobs.
1890	Medical schools: 106 for regulars, 16 for homeopaths, 9 for Eclectics, and 2 for physiomedicals.
1890	Sherman Antitrust Act aims to restrict monopolies and price fixing.
1890s	Automobiles first produced; physicians among first to buy cars
1893	Johns Hopkins Medical School opens and becomes the standard by which other schools are judged.
1895	National Medical Association formed by African American physicians who were denied admittance to the American Medical Association
1899	Thorstein Veblen introduces "conspicuous consumption" in <i>The Theory of the Leisure Class</i> . In this same year, Andrew Carnegie writes "The Gospel of Wealth" on the duties of "the man of wealth" to the worthy.

Date	Selected Historical Event in the United States
1906	Upton Sinclair's horrific accounts of meatpacking plants in <i>The Jungle</i> prompts federal investigation. Public outrage prompts food safety legislation in 1906 but little is done about appalling working conditions.
1910	Publication of Abraham Flexner's report, <i>Medical Education in the United States and Canada</i> .
1914	Clayton Act states that "human labor is not to be treated as a commodity or article of commerce" and protects labor organizing
1915	American Medical Women's Association formed.
1917	State laws change to require one-year internships and African Americans are denied internships and hospital privileges by most hospitals.
1920s	Skeletal samples of black American populations, both slave and free as late as the 1920s, suggest rates of malnutrition, infection, and death that equal or exceed those of more prehistoric groups
1920s	In 1873 there were fewer than 200 hospitals, by 1910 over 4,000 and by 1920s more than 6,000
1921	Sheppard-Towner Act authorizes appropriations to states to improve health of children and mothers is opposed by organized medicine
1930	Reorganized under the Ransdell Act, the Hygienic Laboratory becomes the National Institute of Health (NIH)
1932-1972	Tuskegee Syphilis Study, sponsored by the United States Public Health Service, violates human rights of African American men in Alabama.
1933	American Hospital Association endorses hospital prepayment plans and establishes list of their essential characteristics. This leads to the establishment of Blue Cross.
1934	Private companies first offer commercial insurance against the cost of hospitalization.
1935	Congress passes the National Labor Relations Act (Wagner Act) to outline workers' rights to form unions and bargain collectively.
1938	AMA indicted on charges of violating the Sherman Anti-Trust Act in response to their "restraint of trade" actions against "cooperative medicine," non-profit Group Health Association. AMA's legal team argued that "medicine was a profession, not a trade" so antitrust laws are not applicable. Supreme Court of 1943 upholds conviction.
1939	Doctors associated with the California Medical Association start the first Blue Shield as an alternative to state-run insurance program.
1940s	Average patient load 18-22 patients per day for general practitioners compared with 5-7 patients per day in 1850s due to urbanization, improved transportation and communication.
1941	Kings County Physicians Guild starts and has 700 members in 1966
1944	Public Health Service Act defines the shape of medical research
1946	Hospital Survey and Construction Act, also known as Hill-Burton program, increases the number of "doctors' workshops"
1947	NIH budget \$8 million
1948	When Congress creates National Heart Institute, NIH becomes the National Institutes of Health. "Categorical approach" of NIH calls attention to one disease at a time for funding.

Date	Selected Historical Event in the United States
1950	National Science Foundation established. Congress authorizes Surgeon General to set up research institutes as he sees fit. Medical researchers go directly to Congress rather than through a unified science foundation.
1955-1960	NIH budget grows from \$81 to \$400 million with Congressional support
1965-1966	Medicare-Medicaid Act enacted, despite bitter opposition by the American Medical Association, and "charity medicine" disappears. Due to higher fees and increased number of patients, average physician's earnings increase by 11 % in 1966.
1966	NIH budget now more than \$1 billion
1969	Federal Coal Mine Health and Safety Act provides monthly cash benefits for miners disabled with pneumoconiosis (black lung disease.)
1972	Union of American Physicians and Dentists founded in San Francisco. With a membership of 6,000, this union contrasts with the demise of 24 other physicians' unions that failed since the early 1970s.
1973	Health Maintenance Organization Act
1974	National Health Planning and Resource Development Act
1975	Committee on Interns and residents strikes against the League of Voluntary Hospitals to demand workweek not to exceed 80 hours
1976	Cancelled surgeries during medical malpractice strike in Los Angeles County in California estimated to save 55 to 153 lives. James argues that this strike "was responsible for more deaths prevented than lives lost" (1979: 443)
1980-1988	Ronald Reagan serves two terms as President of the United States. The "Reagan Revolution" or "Reaganomics" is characterized by identification of government as the problem rather the solution, attempts to reform the public sector to make it behave like the private sector, and supply side or "trickle-down" economics.
1983	Social Security Amendment—Section 603 institutes Diagnostic Related Group financing
1986	Technology Transfer Act codifies partnerships between NIH researchers and private-sector development of therapeutic products
1987	Physicians for a National Health Program starts as a single-issue advocacy organization for universal, comprehensive single-payer national health insurance.
1987	Third edition of the <i>Diagnostic and Statistical Manual of Mental Disorders</i> legitimizes "social phobia" as a disease. In 1999 the Food and Drug Administration approves Paxil for social phobia and in this year GlaxoSmithKline spends \$91.8 million in direct-to-consumer advertising
1996	Characterized as a revolt against managed care, first "boutique" or "concierge" physician practice, MD2, starts in Seattle
1997	Ad Hoc Committee to Defend Health Care, physicians and nurses from Massachusetts issue "Call to Action" to protest how "market medicine treats patients as profit centers" (1997: 1733).
1999	AMA creates Physicians for Responsible Negotiation (PRN) but does not encourage doctors to join it or permit strikes. AMA severs relationship with PRN in 2004.

Date	Selected Historical Event in the United States
2000	Bill and Melinda Gates start their foundation with a \$24 billion endowment, which makes it the wealthiest foundation globally.
2000	Direct to consumer advertising for prescription drugs by pharmaceutical companies triples between 1996-2000. This amount reaches nearly \$2.5 billion in 2000. Promotion to health care professionals still accounts for more than 80 percent of pharmaceutical company advertising—more than \$13.2 billion in 2000.
2000	Women make up 46% of those entering medical school, but comprise only 12% of full professors, 7.5% of department chairs, and 3.25% of medical school deans.
2002	From a total of \$300 in 1887, NIH has been appropriated nearly \$23.4 billion for 2002. NIH now has 27 components with 84% of its investment going to extramural grants.

\*Sources: (Beck 1966; Blackbird 1887; Budrys 1997; Burrow 1977; Calloway 2001; Carnegie 1962; Cohen 1989; Council on Graduate Medical Education 2002; Elliott 2003; Gevitz 2000; Harden; Karshmer 1993; Krause 1996; Ravenel 1921; Romano 2001; Rosenberg 1987; Rosenthal et al. 2002; Savoie 1994; Starr 1982; Stevens 1971; Vandervall 1917; Wiebe 2002; Wolinsky and Brune 1994; Wolpe 1999; Zinn 1980).



**Exhibit 3.3 Timeline of Selected Historical Events in Canada\***

Date	Selected Historical Event in Canada
18,000-10,000 BCE	Aboriginal peoples migrate to North America
1534-1542	Jacques Cartier's voyages to the St. Lawrence Valley. Aboriginal people introduce Cartier to white bark of cedar to treat scurvy. North American aboriginals were also familiar with foxglove ( <i>digitalis</i> ), laxative, diuretic, emetic, and antipyretic substances.
1629-1633	No less than 22 surgeons or apothecaries arrive with colonists in New France.
1634-1640	Smallpox, measles, and influenza kill half the Huron people in Ontario
1639	Hôtel-Dieu Hospital founded in Quebec, financially supported by Crown and benefactors, and run by religious women.
1640	First epidemic of smallpox decimates aboriginal people in New France after arriving on infected ship, the <i>Rubis</i> .
1643	Hôtel-Dieu Hospital founded in Montreal
1655	In exchange for an annual fee, surgeon Étienne Bouchard signs an agreement to tend to the medical needs for 46 Montreal families, "except the plague, the great pox, leprosy, epilepsy, and the operation of the stone."
1663	Arriving as ship's surgeons or army surgeons, there are six practitioners per 1,000 inhabitants in New France
1681	Hôtel-Dieu Hospital of Montreal employs 2 surgeons to attend the hospital on a daily basis
1700s	Michel Bertier (1695-1740), king's surgeon at Hôtel-Dieu of Quebec, accused of hastening bishop's death by "all too frequent blood-lettings."
1759	Quebec City conquered by the British
1763	Treaty of Paris cedes most of North America to the British
1774	Quebec Act extends Quebec's Territory and grants rights to the French
1791	Constitutional Act (Canada Act) creates Upper and Lower Canada
1795	Legislation to control registration of physicians introduced in Upper Canada. Doctors lobby for prohibition against any but allopathic practitioners. Legislation repealed in 1806 "on the grounds that people should be free in their choice of practitioners to cure their ailments."
1824	Medical teaching begins at the Montreal Medical Institution which becomes the Faculty of Medicine at McGill University in 1829
1832	Government appoints Sanitary Commission and Board of Health to respond to cholera arriving by ship. Grosse Isle in the St. Lawrence established as site for quarantine.
1841	Act of Union creates Canada East and Canada West
1843	Faculty of Medicine at University of Toronto established. Bilingual school established as l'Ecole de Medecine et de Chirurgie de Montreal, precursor to the Université de Montreal
1847	College of Physicians and Surgeons of Lower Canada formed to regulate practitioners

Date	Selected Historical Event in Canada
1852	Informal group starts the Upper Canada Journal of Medical, Surgical and Physical Science
1859	Homeopathy is legalized. They establish a board to examine and license practitioners.
1861	Eclectics establish board
1865	In-fighting between "school men" and practitioners delay a unified stance for education, practice, and licensing in Upper Canada. In 1865 self-regulatory licensing legislation passes and is revised in 1869.
1867	Dominion of Canada forms. British North America Act situates governance of health and education as purview of provinces.
1867	Canadian Medical Association founded.
1867	Doctors in Newfoundland are paid a yearly retainer to care for fishermen and their families until this year when doctors in St. John's demand fees for their service. Press of the day regards this as a "progressive step forward."
1869	Ontario Medical Act creates College of Physicians and Surgeons of Ontario. Eclectics were excluded in 1874 and homeopaths in 1960.
1874-1884	During William Osler's tenure at McGill University, almost all of the subjects for dissection are obtained illegally. Osler pays some of the poor in advance for their organs and other bodies are obtained by "Osler's resurrectionists" by theft or coercion.
1883	Miners in Glace Bay colliery win a formal agreement for a "medical check-off" system that allows workers to use hospital and physician services of their choosing. This wage deduction system paid a set fee for each patient to the doctor (capitation).
1910	Publication of Abraham Flexner's report, <i>Medical Education in the United States and Canada</i>
1912	Canada Medical Act, standardizing licensing procedures across Canada, passes.
1912	Canadian Public Health Association founded.
1918	Influenza arrives on troopship, <i>Anaguayan</i> , and quickly spreads despite quarantine at Grosse Isle. Impact of flu strengthens support for federal health authority.
1919	Parliament creates federal Department of Health
1919	System of universal medical insurance suggested by Mackenzie King as part of Liberal Party platform
1922	Frederick Banting and Charles Best treat first patient at Toronto General Hospital. The University of Toronto enters into relationship with Eli Lilly Company to manufacture insulin.
1929	Royal College of Physicians and Surgeons of Canada is established to oversee medical education of specialists
1936	Norman Bethune allies with other doctors, nurses, and social workers to form the Montreal Group for the Security of People's Health to argue for a state-supported medicare system in Canada. Outraged by the recalcitrance of the Canadian Medical Association, he sails for Spain's War where he develops a method to transport blood to battlefields.
1943	Association of Canadian Medical Colleges forms

Date	Selected Historical Event in Canada
1945	Universal medical insurance is proposed at the Dominion Provincial Conference on Reconstruction but is opposed by provinces who argue for free-market health insurance
1947	Saskatchewan's CCF government implements public health insurance for hospitals
1948	Mackenzie King's government passes the National Health Grants Program to build hospitals. This starts hospital construction boom.
1950s	Inuit number 10,000 to 11,000 across the Arctic of which at least one-third are infected with tuberculosis. One of every seventh Inuit was hospitalized in sanatoria in the south of Canada by 1956. People from small settlements were herded onto the medical ship to be X-rayed and then often forcibly evacuated without a chance to say goodbye. Some of the Inuit were sent home to the wrong communities or "lost."
1951	Canadian Sickness Survey demonstrates morbidity varies by income.
1953-1961	Of the 3,815 physicians who immigrated to Canada during this time, 46.2% are from the United Kingdom and the Republic of Ireland. Next largest national group is American with 471 physician immigrants or 12.4% of total.
1957	Parliament passes Hospital Insurance and Diagnostic Services Act to cover hospitalization. Federal government picks up 50% of the costs, if provincial programs meet conditions of comprehensiveness, accessibility, universality of coverage, public administration, and portability of benefits. Many people are hospitalized for diagnostic testing, as charges at physicians' offices are not covered.
1961	Royal Commission on Health Services, chaired by Supreme Court Justice Emmett Hall, is appointed by the federal government. Their report recommending universal health care leads to Medicare in 1966.
1962	CCF/NDP government of Saskatchewan implements Medical Care Insurance Act on July 1, and 90% of the province's doctors go on strike for 23 days.
1963	Steelworkers' union in Sault Ste. Marie, Ontario creates the first community health centre. Multidisciplinary, salaried practitioners and community board approach of community health centre is opposed by Sault St. Marie Medical Society in media campaign. Canadian Medical Association warns the centre "could endanger the welfare of a community" and abrogate "the best practice of medicine" as well as "the democratic rights of free people" (Harden 1999: 206).
1966	National Medical Care Insurance Act (Medicare) passes and is implemented in 1968. All provinces are fully participating in 1971. This covers medical services, such as physicians' fees, that were not covered previously. Cost sharing is split equally between federal and provincial governments.
1974	Minister of National Health and Welfare, Marc Lalonde, releases <i>A New Perspective on the Health of Canadians</i> . It is valorized for its "health beyond health care" approach in promoting lifestyle, nutrition, and environmental factors. It is also critiqued for "blaming the victim" and legitimating a retreat from federal responsibility for health care.

Date	Selected Historical Event in Canada
1977	Pierre Trudeau's Liberal government and the provinces negotiate the Established Programs Financing Act (EPF). Cost sharing shifts to "block grants" by capita with federal funding to grow at the same rate as the GNP.
1979	Medical Reform Group founded in Ontario as advocacy group of physicians advocating population health principles and salaried reimbursement for physicians.
1980	Supreme Court Justice Emmett Hall's committee to reevaluate Medicare releases report that unless extra-billing is banned, Medicare is doomed.
1982	Constitution Act replaces BNA of 1867. This includes the Canadian Charter of Rights and Freedoms of which Section 7 has implications for health.
1984	Canada Health Act passes with five conditions for the provinces: comprehensiveness, accessibility, universality of coverage, public administration, and portability. User fees and extra-billing were prohibited as a condition for federal funding. The Canadian Medical Association and the Ontario Medical Association each file unsuccessful lawsuits.
1984-1993	Brian Mulroney serves as Prime Minister of Canada. Although arguably less ideological than Thatcher or Reagan, Mulroney's policy aims were influenced by and consistent with Thatcherism and Reaganomics.
1986	Mulroney's Conservative government changes the growth formula for EPF to GNP growth minus 2%.
1986	<i>Achieving Health for All: A Framework for Health Promotion</i> , influenced by Britain's <i>Black Report</i> , is released by Health Minister Jake Epp as follow up to Lalonde Report of 1974.
1987	Estimated 40-50% of the Ontario Medical Association's 17,000 members go on strike for 25 days to protest ban on extra-billing.
1990	Mulroney's government passes Bill C-69, freezing EPF for 3 years, after which future EPF growth will be based on GNP minus 3%.
1991	Mulroney's government passes Bill C-20, which freezes EPF growth for 2 additional years—making a 5-year freeze in total—before the new formula of GNP minus 3% comes into effect. This bill, C-20, also makes it possible for the federal government to withhold any federal transfer payments from provinces in breach of the Canada Health Act.
1994	<i>Strategies for Population Health: Investing in the Health of Canadians</i> , produced by the Advisory Committee on Population Health and accepted by the Conference of Ministers of Health, marks transition from health promotion to population health paradigm in Canada.
1994	Prime Minister Jean Chrétien launches the National Forum on Health to investigate four key areas: values; striking a balance; determinants of health; and evidence-based decision making.
1996-1997	Federal contribution to health and social services consolidated into the Canada Health and Social Transfer.
1998-1999	Federal share of health spending has changed from 50% to 42% in the mid-1970's to 33% in 1984 to 23.5% in 1993 to 10.2% in 1998-1999.
1999	Inuit gain self-rule over their ancestral homelands with creation of territory of Nunavut

Date	Selected Historical Event in Canada
2000-2002	Standing Senate Committee on Social Affairs, Science and Technology conducts a two-year, 400 witnesses, and six-volume study on health care in Canada chaired by Michael Kirby.
2001-2002	Quebec, Saskatchewan, Northwest Territories, Alberta, British Columbia, New Brunswick all issue reports on health care reform
2001-2002	Commission on the Future of Health Care in Canada, chaired by Roy Romanow, generates responses from tens of thousands of individual Canadians and hundreds of organizations over 18 months.

\*Sources: (Badgely and Wolfe 1967; Barlow 2002; Basch 1990; Bliss 1999; Calloway 2001; Clair 2001; Clarke 2000; Cuff 2001; Fuller 1998; Fyke 2001; Gelfand 1987; Grygier 1994; Judek 1964; Kirby 2002; Leger 2002; Legowski and McKay 2000; MacFarlane et al. 1965; Mazankowski 2001; National Forum on Health 1997; Rachlis and Kushner 1994; Roddick 2001, 2002; Romanow 2002; Savoie 1994; See 2001; Shryock 1967).

## Organized Medicine as a Guild: Witch-Burning, Midwife-Bashing and Quack-Hunting as Activities

The predominant discourse that describes the history of medicine as Great Men doing Great Deeds was written by the literary and political elites of the age under consideration. Moreover, these scribbling elites tended to be most fascinated by those hired elites who treated important elites as patients; “we are more in the dark about those who cared for the craftsman, the peasant, and the slave” (Freidson 1988: 19). In solidarity with Howard Zinn who writes that “we must not accept the memory of states as our own,” (1980: 9) this section is disinclined to accept the memory of organized medicine as our own.

Instead, let us turn to the fugitive literature that illustrates examples of how monotheistic notions, grounded in specific religious traditions often of the hard variety, have influenced the philosophy and practice of medicine. The systematic persecution of women healers by the Church and State as witches in the Middle Ages was grounded on the testimony of male doctors who made judgments about whether certain ailments were caused by witchcraft and if particular women were witches. Many thousands<sup>84</sup> of people were murdered for being witches<sup>85</sup> from the 14<sup>th</sup> to the 17<sup>th</sup> century in Europe<sup>86</sup> with an estimated 85% of those executed being female (Ehrenreich and English 1973: 7-8). Non-professional healing was deemed equivalent to heresy: “If a woman dare to cure *without having studied* she is a witch and must die” (Ehrenreich and English 1973: 19). As women were generally prohibited from university training, testimony of a woman’s competence at healing thus confirmed guilt. Skilled herbalists, bone-setters, and midwives were accused of “magic” when their patients improved as the “men of science” were prescribing “touching a needle to a caterpillar and then the tooth” for toothache, consulting astrology, and trying to turn lead into gold by alchemy (Ehrenreich and English 1973: 17). This attack on the “magic” of the women healers

disproportionately affected the poor who depended on them for their care. Kings and nobles had access to court physicians, some of whom were priests, whose medicine was sanctioned by the Church who controlled the universities (Ehrenreich and English 1973: 13-17).

The history of privileging Great Men over Any Women continues five hundred years later as physicians argue against medical education for women on religious grounds. Working from the premise that “marriage is a natural and divine institution,” Dr. Williams in 1850 proclaimed that not to be married is unnatural and morally wrong. His argument concludes that “the marriage condition is not compatible with the duties of a physician so far as regards females, and that its refusal is *naturally, religiously and socially wrong* (Williams: 131-132). It is pertinent to note the language of religion, nature, and beneficence was also used by medical professor, Samuel Cartwright in 1851, to normalize slavery:

A knowledge of the great primary truth, that the negro is a slave by nature, and can never be happy, industrious, moral or religious, in any other condition than the one he was intended to fill, is of great importance to the theologian, the statesman, and to all those who are at heart seeking to promote his temporal and future welfare (Cartwright: 103)

Not coincidentally, this beneficence was for the good of the slave just as women were advised by science to avoid higher education in the 19<sup>th</sup> century<sup>87</sup> for their own good lest it make them insane or cause their uteruses to atrophy (Ehrenreich and English 1978a: 127-128).

“The Midwife Problem”<sup>88</sup> is another telling example of differentiating and often expropriating expertise in order to corner a medical monopoly in the interest of physicians’ incomes, if not the best interests of women and children. Without the means and perhaps the desire to glorify uncounted numbers of babies delivered and mothers comforted, the untold stories of midwives in early North America are overtaken by tales

of midwifery by professional medicine men. Shryock complains that “since midwives lacked any scientific training, obstetrics proceeded on the level of folk practice and with consequences which may be easily imagined” (1936: 85). The first two physicians in New England to be “regular accoucheurs” in the 1750s were praised for transferring to “the profession, from the hands of ignorant and uneducated females, the practice of a difficult and delicate art (Beck 1966: 24). As with the previous account of women healers who were castigated for healing without the education systematically denied them, it seems unjust to complain of “ignorant and uneducated” women in North America given that their education was not generally supported by physicians, in contrast to a strong midwifery training tradition championed by the medical elite and funded by governments in Europe.

The suppression of midwifery by organized medicine embodied race, gender, and class discrimination<sup>89</sup> and yet was dressed up once again as concern for the patients. A public campaign against midwives warned against germs personified:

They may wash their hands, but oh, what myriads of dirt lurk under the fingernails. Numerous instances could be cited and we might well add to other cause of pyosalpinx “dirty midwives.” She is the most virulent bacteria of them all, and she is truly a micrococcus of the most poisonous kind (Ehrenreich and English 1978a: 95-96).

This “micrococcus” was often identified as “foreign” and “un-American” as the midwives are described as arriving in the holds of ships with other immigrants (Ehrenreich and English 1978a: 96). Some doctors clearly felt that it “lowered the esteem of doctors to have uneducated women doing the same job as they” (Mitchinson 1991: 172). The “problem” with midwives caring for the poor was that it deprived America’s most rapidly developing specialty, obstetrics-gynecology, of teaching “material” in the public/charity/ university hospitals as Dr. Charles Zeigler complained:



It is at present impossible to secure cases sufficient for the proper training in obstetrics, since 75% of the material otherwise available for clinical purposes is utilized in providing a livelihood for midwives (Ehrenreich and English 1978a: 95)

While it is a bit perplexing that the livelihood of midwives should be less worthy than that of physicians, the main point here is to juxtapose laboring woman as instrumental “material”<sup>90</sup> for teaching with the stance of the midwife:

The early-twentieth-century midwife was an integral part of her community and culture. She spoke the mother’s language, which might be Italian, Yiddish, Polish, Russian. She was familiar not only with obstetrical techniques, but with the prayers and herbs that sometimes helped. She knew the correct ritual for disposing of the afterbirth, greeting the newborn or, if necessary, laying to rest the dead. She was prepared to live with the family from the onset of labor until the mother was fully recovered (Ehrenreich and English 1978a: 93-94).

An anonymous pamphlet published in Boston<sup>91</sup> in 1820 outlined two main objections to midwives as “women were unsafe to attend deliveries” and that “no true woman would want to gain the knowledge and skills necessary to do so” (Wertz and Wertz 1994: 179). As recently as the fall of 1993, Dr. Augustin Roy, former president of the regulatory agency for physicians in Quebec, gave this opinion when asked whether midwifery should be legalized in Quebec: “You might as well make prostitution legal. More people are asking for prostitution than midwives” (Rachlis and Kushner 1994: 225). In addition to the lack of esteem that Dr. Roy presumably has for both midwifery and the “world’s oldest profession” and his notions of equivalency in his telling metaphor, this quotation is fascinating for its logic of berating midwifery for its lack of demand that the medical profession helped to engineer. An article in the *Canadian Lancet* of 1874 pointed out that it was men who invented the “instruments of the obstetric armory, not women” and that “if only women understood this they would feel a debt of gratitude” (Mitchinson 1991: 172). The invention of forceps, the use of which was restricted by the surgeon’s guilds, was “the fatal blow to the female midwives” (Roush 1979: 34). Eager to build up practices among a surplus of practitioners and with professional

organizations, if minimal scientific authority, behind them, “unorganized midwives were an easy competitive target for medicine”<sup>92</sup> (Wertz and Wertz 1994: 175).

Despite the excellent care that many experienced midwives provided,<sup>93</sup> with less risk of drastic intervention or infection<sup>94</sup>, it became the fashion for middle and upper class women to consult physicians for delivery. An important point to note is that physicians were less likely than midwives,<sup>95</sup> then as now, to provide obstetrical care for the poor, minority populations, or those in rural areas (DeVries 1985: 27). It is interesting to note that long standing objections to midwives based on gender and professional bias currently tend to be framed as issues of liability in an increasingly litigious “risk culture” often associated with the new public health.

Elliott Krause defines guilds “as social groups, institutions created by groups of workers around their work, their skill, or craft” and maintains that in any era, the same questions are at the heart of periodic ebbs and flows in their power (1996: 2). The key dimensions for Krause are power and control over association, the workplace, the market, and the relation to the state (1996: 3). By association Krause means the right for guild member to create their own rules, especially who might be trained. As early as the 1400s special exemptions to the rules on entry and length of training for the sons of guild masters existed (Krause 1996: 4); the resulting nepotism fueled perceptions of guild elitism. While it was vital to keep people of the wrong class, gender, and race/ethnicity out, it was also essential to keep the right people within the guild. Katherine Park (1985) studied the desertion of the sons of aristocracy from medicine to law in early Renaissance Florence and noted the guild itself lost status once the sons of the elite no longer dominated it.

Paul Starr notes that in mid-nineteenth century America a physician’s standing was determined by his family background and the status of his patients rather than on the nature of medicine as an occupation (1982: 81). As Starr puts it: “the doctor in

America was more a courtier than an autocrat" (1982: 80). Among the allopathic physicians, the elite were gentlemen who had often trained in Europe or at the Medical College of Philadelphia, King's College in New York, or Harvard. Less elite medical students often studied at one of the more than 800 medical schools that opened and often quickly closed between 1765 and 1905, many of them proprietary (Wertz and Wertz 1994: 177). In keeping with the worldview of the time, determinations of sickness and health were class-related so that physicians had different expectations for different groups. Farm women were expected to be more robust than delicate women of the upper classes, who were often treated for hysteria and the previously noted weakening effects of higher education (Ehrenreich and English 1978b).

Andrew Abbott (1988) maintains that professions must be considered as part of a system in which they jostle each other for jurisdiction to protect their own "professional project." While the norms of allopathic treatment included bleeding sometimes large amounts of blood<sup>6</sup>, blistering, leeches, and purging using calomel, a chloride of mercury, non-regular healers, such as homeopaths, osteopaths, herbalists, bonesetters, and midwives, were often popular for using gentler, if sometimes no more effective, treatments. An oversupply of doctors who trained for variable lengths of times under heterogeneous circumstances competing for market share against a wide variety of alternative health practitioners in a context of a strong tradition of self-care, where "each man was his own doctor" was a clear challenge to medicine as a profession (Starr 1982).

Long before the more effective treatments often associated with modern medicine came into use such as insulin in 1922 or antibiotics after World War II, the American Medical Association (AMA) was founded in 1847. This organization was originally started as a committee to generate reform of medical education but it seems that the committee reached an impasse when medical school faculties were unwilling to give up any autonomy in the process. In an example of "a tail wagging the dog," the

national medical society was invented to create an organization that would receive ongoing reports from the education reform committee (Baker 1999: 20). As advocates of educational reform, licensing, and a relentless battle against any but allopathic physicians, the AMA championed “professional birth control”<sup>97</sup> for organized medicine.

Controlling the definition of a problem and what constitutes its successful resolution is a hallmark of professional work (Abbott 1988). As late as 1911, George Bernard Shaw could still make a compelling case that:

As a matter of fact, the rank and file of doctors are no more scientific than their tailors; or, if you prefer to put it the reverse way, their tailors are no less scientific than they...It does happen exceptionally that a practicing doctor makes a contribution to science (my play describes a very notable one); but it happens more oftener that he draws disastrous conclusions from his clinical experience because he has no conception of scientific method, and believes, like any rustic, that the handling of evidence and statistics needs no experience. The distinction between a quack doctor and a qualified one is mainly that only the qualified one is authorized to sign death certificates, for which both sorts seem to have about equal occasion (Shaw 1980: 25).

Shaw’s assertion that both qualified and quacks had about equivalent outcomes seems plausible when considering the treatment options available and the “unqualified qualified.”<sup>98</sup> What is fascinating is that irrespective of outcomes, organized medicine has been ruthless about defining non-allopaths as “quacks” needing eradication:

From the very first the American Medical Association has prosecuted its war on quackery and more than any other agency in our country can take the credit for the vast improvement that has occurred in the abolition of nostrums, secret medicines and quackery. At the session on May 7, 1847 Dr. John B. Johnson of Missouri introduced a resolution in which he pointed out that numerous and important evils result from the universal practice of allowing persons almost wholly ignorant to engage in apothecaries and still greater from the universal traffic in secret medicines (Fishbein 1947: 31).

From this resolution in 1847 to the AMA’s Committee on Quackery of 1963 to actions against chiropractors described by U.S. District Court Judge Getzendanner as a “conspiracy” in 1988, “irregular” or “sectarian” practitioners were consistently portrayed as dangerous and unscientific (Wolinsky and Brune 1994). The AMA and state

affiliates also used this argument, including quackery imagery, in 1993 to warn against increasing autonomy of nurse practitioners as it “may increase the medical risks to patients and the ultimate cost of care” (Wolinsky and Brune 1994: 142). Setting aside research that demonstrated that advance-practice nurses could provide as good or better primary care at lower cost, several state medical societies warned that “some ‘daffy ducks’ were trying to ‘fowl up’—one state said ‘duck up’—medical care by lowering standards and allowing unqualified people to practice medicine” (Wolinsky and Brune 1994: 142).

Biomedicine has such a monopoly over the popular understanding of how science is conceptualized that alternate ways of organizing healing practices outside of the current mainstream may incite incredulity. It may seem strange to read that “homeopathy was not a pseudoscience of the nineteenth century; it was a science of the nineteenth century” (Wolpe 1999: 222). Despite the fact that the homeopaths were more advanced than the allopaths in creating systematic experiments to create a pharmacopoeia, the AMA Code of Ethics of 1847<sup>99</sup> excluded eclectics and homeopaths on the basis of not being scientific. In order to exclude competition, orthodox medicine called everything that was not itself quackery. Science involved adhering to the existing system of therapeutics, not to methodological rigor in empirically validating effective treatments. Wolpe makes a convincing argument:

The lack of scientific justification for orthodox therapies themselves suggests that science was used at least as much as a club to beat over the heads of rivals as an assessment tool in adjudicating therapeutic disputes. This was reflected in the fact that the AMA code was ambiguous about who was a physician but not ambiguous about who was not: homeopaths and eclectics, their main rivals for patients. “Scientific medicine” became synonymous with bleeding, cupping, and purging (1999: 226).

As we have seen, a similar club was used to protect the fortunes of allopathic medicine against midwifery and nurse practitioners, without respect to patients’ comfort or ability to pay, clinical outcomes or system efficiency.

Given this background, we can now appreciate Ehrenreich and English's eloquent summary of the dominant discursive history of American medicine:

...there was always one *true* American medical profession—a small band of men whose scientific and moral authority flowed in an unbroken stream from Hippocrates, Galen and the great European medical scholars. In frontier America these doctors had to combat, not only the routine problems of sickness and death, but the abuses of a host of lay practitioners—usually depicted as women, ex-slaves, Indians and drunken patent medicine salesmen. Fortunately for the medical profession, in the late 19<sup>th</sup> century the American public suddenly developed a healthy respect for the doctors' scientific knowledge, outgrew its earlier faith in quacks, and granted the true medical profession a lasting monopoly of the healing arts (1973: 21).

In contrast to a mythological "healthy respect for the doctors' scientific knowledge," Eliot Freidson points out that much of the competition that allopathic medicine experienced was driven by patients' understandable disappointment with purging and bleeding that was offered by 18<sup>th</sup> and 19<sup>th</sup> century physicians as the "educated scientific treatment of choice" (1988: 20).

### Science at the Prow: Professionalizing Organized Medicine

This section argues that the growing acceptance of biomedicine as the dominant discursive framework (as characterized in Exhibit 2.2) consolidated the legitimacy of medicine as "a sovereign profession"<sup>100</sup> and ensured its preeminence "akin to that of state religions" of yesteryear based on "an officially approved monopoly" of the right to define health and treat illness (Freidson 1988: 5). The analogy between medicine and religion is apt because the metaphors of early proponents of biomedicine were devotional. Sir William Osler was a saintly figure,<sup>101</sup> the sacred text of Osler's *Principles and Practice of Medicine* converted Frederick Gates and by his influence, the Rockefeller Foundation, to scientifically based medicine<sup>102</sup>, and the Holy Ghost hovered over Osler's metaphor of "the spirit of science brooding over the waters."<sup>103</sup>

This is not to suggest that the ascendancy of biomedicine was uncontested or that motives were unmixed. Although the achievements of Lister, Koch, and Pasteur were being incorporated into the practices of the eclectics and homeopaths (Shryock 1967: 44), some of the “rank-and-file regular doctors distrusted scientific medicine and the elite doctors who crusaded for it” (Ehrenreich and English 1978a: 89).<sup>104</sup> During the years 1890 to 1910 many states did not have effective licensing regulations and “diploma mills” still proliferated. Dr. L. Connor observed that the profession still contained “a vast number of incompetents, large numbers of moral degenerates, (and) crowds of pure tradesmen” to the American Academy of Medicine in 1898 (Shryock 1967: 60).

Proprietary schools are perhaps at the heart of the quality versus access dilemma as it applies to medicine at this point in American history.<sup>105</sup> The economic logic of entrepreneurial proprietary medical schools was to attract students, collect fees, teach students with the resources available, and set them loose in a few months or few years depending on the program (Starr 1982). The quality of the educational experience and the competence of the graduates varied considerably at the same time as the proliferation of schools with lower barriers to entrance provided opportunities for African-Americans, women, and people of the lower classes. Physicians who ran the proprietary schools had a financial interest in graduating as many people as possible “while the profession was flooded”<sup>106</sup> (Starr 1982: 105). Not only did the flood result in direct economic competition but it was difficult to become a “respected profession” so long “such riff-raff jeopardized efforts to raise the doctor’s status in society” (Starr 1982: 117). Much of the opposition<sup>107</sup> to medical licensing came from physicians of the proprietary schools although the first licensing laws required applicants to have a medical diploma which increased demand for their services (Starr 1982: 105). Steadily increasing requirements set by state licensing boards changed the economic viability of

the medical schools such that the number of schools declined from the highest number of 162 in 1906 to 131 in 1910 (Starr 1982: 118).

Although this trend was already in motion by 1910, the Canadian Royal Commission on Health Services was correct to highlight 1910 as “the beginning of a new era in medical education in North America” (MacFarlane et al. 1965: 18).<sup>108</sup> This new era arose from the confluence of the excitement generated by the promise of scientifically based medicine, “professional birth control,” and the philanthropic interests of American “robber-barons.” As previously mentioned, John D. Rockefeller<sup>109</sup> funded the Rockefeller Institute for Medical Research which was based on the model of European laboratory research to produce “gentlemen scientists” (Ehrenreich and English 1978a: 86). In 1904 the American Medical Association formed the Council on Medical Education to “elevate and standardize the requirements for medical education” (Starr 1982: 117). They inspected the 160 medical schools in existence at the time of their study in 1906 and fully approved of only 82 schools as Class A. “As professional ethics forbade physicians from taking up cudgels against each other in public” (Starr 1982: 118), they invited the Carnegie<sup>110</sup> Foundation for the Advancement of Teaching to do so instead.<sup>111</sup> This foundation chose Abraham Flexner, whose brother Simon was the president for the Rockefeller Institute for Medical Research, to spearhead the effort. Abraham Flexner visited every medical school in North America in 1909:

Being from Carnegie, he smelled of money. Being a Flexner, he sounded like Science. His message was simple: conform to the Johns Hopkins model, complete with laboratories in all sciences, salaried professors, etc. or close. For the smaller, poorer schools, this could only mean one thing: close. For the bigger and better schools (i.e., those which like Harvard already had enough money to begin to institute the prescribed reforms), it meant the promise of fat foundation grants for further reforms (Ehrenreich and English 1978a: 87).

State legislatures and licensing boards added their support for the standards outlined in Abraham Flexner’s *Medical Education in the United States and Canada* (Shryock



1967: 62-63). The number of medical schools declined to 66 in 1933 and the flooding of physicians ebbed with the physician-population ratio going from 1:600 in 1900 to 1:763 by 1938 in the United States (Shryock 1967: 64).

Although Flexner stated that “in Canada conditions have never been so badly demoralized as in the United States” due to a remembrance of “English clinical teaching” (Flexner 1910: 13), this was his impression of Canada’s medical schools in 1909:<sup>112</sup>

In the matter of medical schools, Canada reproduces the United States on a greatly reduced scale. Western University (London) is as bad as anything to be found on this side of the line; Laval and Halifax Medical College are feeble; Winnipeg and Kingston represent a distinct effort toward higher ideals; McGill and Toronto are excellent (Flexner 1910: 325).

Halifax Medical College disappeared in 1911 as Dalhousie University assumed responsibility for the medical faculty and London was placed under control of the University of Western Ontario in 1913. Grants from the Rockefeller and Carnegie Foundations in the 1920s permitted “vigorous building programme(s)” and within the decade standard facilities for teaching medical sciences were in use by all Canadian medical schools (MacFarlane et al. 1965: 21). With only eight medical schools<sup>113</sup> and with the population of Canada doubling between 1901 and 1941,<sup>114</sup> physician oversupply was not a problem. In 1901 the physician-population ratio for Canada was 1: 972, it rose to 1: 1,034 in 1931, and then went to 1: 968 in 1941 (Judek 1964: 24).

With improved quality of medical education and effective prophylaxis against an oversupply of physicians in the United States as outcomes of Flexner Report reforms, what about the question of access? There were ten medical colleges that African Americans had access to in 1910 and by 1923, the only two of these institutions that Flexner said deserved to exist, Meharry Medical College and Howard University Medical Department, remained (Savitt 1992: 65). Flexner thought that whites had to

teach the black physician “to feel a sharp responsibility for the physical integrity of his people” and that “the practice of the negro doctor will be limited to his own race” (1910: 180). Fewer schools of higher quality, that would emphasize training in hygiene more than surgery for black physicians, would facilitate a perceived mission of “sanitation and civilization” rationalized as protection for whites against a “potential source of infection and contagion”<sup>115</sup> (Flexner 1910: 180).

The decline of women into the medical profession predated Flexner’s Report. By 1909 only three women’s medical colleges still remained and the total number of female medical students (including those in coeducational schools) dropped from 1,419 in 1894 to 921 in 1909 (Starr 1982: 124). Flexner attributed this decline to reduced interest among women in become physicians and declining demand for women physicians (1910: 179). Or it might have to do with institutionalized sexism: in 1910 more than half of the medical schools did not accept women as students and in 1921 only 40 of the 482 general hospitals approved for internships accepted women interns (Walsh 1992: 58).

More rigorous entrance requirements and increased cost limited the numbers of poor and working class students while “deliberate policies of discrimination against Jews, women, and blacks promoted still greater social homogeneity” (Starr 1982: 124). This homogeneity did not extend to a homogeneous geographical dispersal of medical talent. Flexner insisted that there would be a kind of “spontaneous dispersion” that would widely spread the graduates from the top medical schools (Starr 1982: 125). Not to put too fine a point on it, the affluent, white, male doctors flocked to the wealthier areas of the country<sup>116</sup>: poor rural areas lost physicians relative to population while the wealthier states gained them (Starr 1982: 125).

The smell of money and sound of Science that Abraham Flexner wielded on his peripatetic<sup>117</sup> tour of medical schools in North America are hallmarks of what has come to be studied as the medical industrial complex. Capital, state, and biomedicine have

coagulated into a seemingly undissolvable clot that defies accurate analysis or even intelligible description. Data are inconsistent,<sup>118</sup> opportunities for cognitive dissonance abound,<sup>119</sup> and the center cannot hold.<sup>120</sup> While it is clear that proprietary medical schools needed reform,<sup>121</sup> it is ironic that an investigation into professional norms that were being eroded by self-interest within a proprietary structure<sup>122</sup> was precipitated by entrepreneurial physicians unhappy with a saturated market of providers. Flexner thought that fewer, better doctors, grounded in laboratory biomedicine, would improve the profession and practice of medicine in both clinical and preventive<sup>123</sup> arenas. Instead of extinguishing the profit motive that threatened professionalism, biomedicine's bond with state and capital created new opportunities for it to flourish.

Richard Brown traces the evolution of a medical services system in America that is expensive, yet inadequate in meeting the basic health needs of everyone, to the rise of scientific, technologic medicine devoted primarily to meeting the needs of the corporate class and the medical profession. The impact of the \$300 million that the philanthropic foundations gave for medical education and research from 1910 to 1930 (Brown 1979: 193) was not just felt by the institutional beneficiaries. Articulating the interests of the corporate class,<sup>124</sup> "Rockefeller Medicine Men" "assumed the right to define what kind of health care their society needed" (Brown 1979: 194). In this monotheist interpretation that became the ascending discursive framework, health care became synonymous with the science and technologies of allopathic medicine.

Complementary and/or competing interests, consciously and/or subconsciously motivated machinations, and extrinsic events that affect the trajectories of state, capital, and medicine as a profession are inexorably woven together. Exhibit 3.4 (Selected Intersections of Influential Events for State, Capital, and the Medical Profession in North America) is an attempt to highlight a few of these threads across several significant historical events in order to trace recurrent themes or patterns over time.

Wars, economic depressions, and social movements generate a variety of opportunities and responses from various sectors of society who are differentially rewarded and challenged by market and regulatory forces. Whether foreseen and intended or not, the confluence of parallel interests, kindred sensibilities, and reinforcing discursive frames generates a nexus in 1965 where a “War on Poverty” can be fought alongside a “War on Cancer” and a War in Southeast East Asia (either “Vietnam War” or “American War” depending on one’s geopolitics). The language of crisis precipitates action to address “problems” that scientific, technological, bureaucratic, and business elites define and legitimize by their status as experts.

Markers of the growth of the medicine as increasingly significant in the political economy of industrialized countries may be found in Tables 3.1 and 3.2.

**Exhibit 3.4 Selected Intersections of Influential Events for State, Capital, and the Medical Profession in North America\***

Time Period	Event	Implications for State	Implications for Capital	Implications for Medical Profession
1860-1865	American Civil War	Perpetual tension between federalism and states' rights	War profiteering starts the aggregation of vast amounts of capital (e.g. rise of John D. Rockefeller's fortune).	Massive casualties hone surgical skills. Medical Department of the U.S. Army records published in seven volumes in 1870-1888.
1867	Canadian Confederation	British North America Act creates either a strong federal government with subordinate provinces or pact between autonomous provinces. This will be debated for centuries, as will federal-provincial cost shares for education and health.	Hudson's Bay Company sells Rupert's Land to Canada. After debates, a rebellion, and some massacres, Canada expands as does intense bidding for a charter to construct the Canadian Pacific Railway. Canada's "first serious political scandal" (See 2001: 92) occurs when the Conservatives take campaign contributions in return for the transcontinental railway contract.	As nation states are forming, this is an era of growth of professions and their associations. Canadian Medical Association established twenty years after the American Medical Association.
1893-1897	Depression	"Coxey's Army" marches on Washington demanding public works program. Interstate Commerce Commission created to regulate the railroads.	Factories close. President Grover Cleveland saves the gold standard by exchanging federal bonds for gold. New York banks make \$18 million profit. Farmers faced declining prices for their crops as wealth concentrates in fewer hands.	Cholera, typhoid, and TB prompt support for laboratory science and "social medicine." JAMA editorializes that "the animals at Rock Creek Zoo were better cared for" than the 437 men and 30 horses of Coxey's Army.

Time Period	Event	Implications for State	Implications for Capital	Implications for Medical Profession
1900-1917	Progressive Era	100,000 people march down Broadway after 146 women killed at Triangle Shirtwaist Factory. New York City creates the Bureau of Fire Prevention and a Factory Investigation Commission. Pure Food and Drug Act and Meat Inspection Acts pass in 1906.	Outrage at disgusting abattoirs and women flinging themselves out windows during the Triangle Shirtwaist Factory Fire prompts governmental regulation and support for unions. At turn of century, 1:14 workers are union members. Growth of strong government for the benefit of business elites termed "political capitalism" (Zinn 1980: 342).	Philanthropists support medical reform via Flexner's <i>Report on Medical Education in the United States and Canada</i> .  WWI interrupted the Progressive movement and caused it to falter, including demands for health insurance.
1914-1918	World War I	Canada passes the War Measures Act in 1914 to conscript soldiers and incarcerate people perceived as threats to the state. Over 8,000 immigrants and "radical dissenters" are interned. Implementation of conscription in 1917 exacerbated tensions between French and English. The United States was "neutral" (but shipping war materials) from 1914 until 1917. Lever Act of 1917, Overman Act of 1918, and the National War Labor Board gave federal authority over farm production, commodity prices, industrial raw ingredients, and labor arbitration. The Espionage War Act was used to imprison war and draft opponents.	In Canada, federal government regulates economy, agriculture, and labor relations for war effort. Despite income and business taxes, "there was little question that war was good for business" (See 2001: 108).  War industries were able to obtain loans from the War Finance Corporation. "The war was enormously profitable to the United States....By the end of the war the United States had become the premier economic power in the world" (Burner, Fox-Genovese, and Bernhard 1991: 734).	USA War Department asks AMA to organize medical boards to conduct medical exams for draft.  USA Secretary of Labor William Wilson asks Dr. Alice Hamilton to investigate mysterious epidemic of poisonings at munitions plants in 1915. When she asked the Ordinance Department for a list of factories, she is told that none exist. She follows her nose across New Jersey and pioneers industrial reform.

Time Period	Event	Implications for State	Implications for Capital	Implications for Medical Profession
1918	Prohibition Canada	All of Canada's provinces, except Quebec, prohibited the sale of alcohol during WWI. The federal government prohibited manufacture, sale, and importation of alcohol in 1918. Prohibition was abandoned by the 1920s, with the support of returning soldiers. This experiment "illustrated a growing belief that government should be used to control the social behavior of individuals" (See 2001: 114).	The Bronfman family took the opportunity to parlay their "Seagram Company into the world's greatest distillers largely by slaking a prodigious American thirst" (See 2001: 114).  For those who could not afford smuggled liquor, some deaths were caused by alternative beverages that were laced with iodine, sulphuric acid, creosote, or embalming fluid.	In 1920 AMA tries to reaffirm a resolution adopted in 1917 that "whiskey is not necessary for the proper scientific treatment of influenza" but it is tabled after "tremendous debate." Doctors have a referendum in 1922 and suggest modifications of Volstead Act to permit physicians to "command a pure drug in the form of whiskey or other distilled spirits at a price fixed by the government." Throughout Prohibition, "there was the usual resolution condemning the Volstead Act for interfering with doctors in their practice." AMA encourages local associations to disciple doctors who bootleg (Fishbein 1947: 321-339).
1919-1933	United States	The 18 <sup>th</sup> Amendment of 1919 prohibited the manufacture, sale, and transportation of alcohol until it was repealed by the 21 <sup>st</sup> Amendment in 1933.	Organized crime flourished with the distributional challenges presented by Prohibition.	
1929-	Great Depression	Massive social suffering in the United States and Canada prompts both governments to implement "New Deal" programs to reform economies and create the first elements of the welfare state. Social Security Act signed into law in 1935.	Galbraith points to unhealthy corporate and banking structures, unsound foreign trade, economic misinformation, and income inequalities as factors behind the wild speculation leading to Crash.	American Medical Association opposes President's Roosevelt's plans for Health Security as do capital and labor. Doctors in Saskatchewan receive "relief" as do many other citizens in North America.

Time Period	Event	Implications for State	Implications for Capital	Implications for Medical Profession
1939-1945	World War II	<p>Canada entered the war in 1939. Once again government agencies regulate production and distribution of goods. Wage and price controls enacted to respond to inflation. More than 20,000 Japanese Canadians are interned. Conscription divides French and English Canada again.</p> <p>Prior to entry into war in 1941, Roosevelt supports Britain with \$7 billion in "Lend-Lease" goods in 1941. War Production Board oversees industry and War Labor Board oversees labor. Inflation problematic so Office of Price Administration organized. Between 1941-1945, federal spending came to more than \$321 billion, twice as much as all federal spending from 1789 to 1941. About 110,000 Japanese Americans are interned.</p>	<p>War helps "to break the depression's grip almost overnight." The 400,000 unemployed are absorbed into war-related industries. Union membership doubles. One million working days are lost to strikes in 1943 in Canada. Women enter labor force in both countries as they did in WWI. The process of industrial mobilization in the USA helped to increase the concentration of wealth among fewer players. In 1941 three-fourths of the value of military contracts were handled by 56 corporations. During the war years there were 14,000 strikes. IMF set up to regulate international currency and International Bank for Reconstruction and Development set up to rebuild and "to promote foreign investment."</p>	<p>The majority of U.S. doctors volunteer for military service. Up to 80% of medical students are drafted. Even with all those at war receiving universal medical services, AMA continues to fight against national health insurance. AMA also opposes government health care for dependents of military.</p>



Time Period	Event	Implications for State	Implications for Capital	Implications for Medical Profession
1945-1965	Golden Age of Medicine	Congress passes the Hill-Burton Act, which generates massive hospital construction. Since it passed in 1946, more than \$4.6 billion in grants and \$1.5 billion in loans have been directed to nearly 6,800 health care facilities in over 4,000 communities. Of those projects, 4,678 were undertaken in the first twenty years of the program. Hospitals develop as local units privileging tertiary care.	Instigating force for Hill-Burton is the American Hospital Association. They finance a multi-million dollar public relations or "educational campaign" to "explore the benefits of free enterprise" and "combat government control in the operation of the nation's hospitals" (Stevens 1989: 216-218). Hill-Burton favors non-profit hospitals but there are pockets of profit-making hospitals in South and West.	AMA reached "its peak as a symbol of the power that an independent profession could reach" during the Truman and Eisenhower administrations (Krause 1996: 38).  Specialty medicine begins in the 1930s and rapidly escalates in 1945-1965.  Real income for U.S. physicians almost doubles from 1947 to 1965 and then peaks in 1972.
1964-1965	Great Society	With 20% of American families identified as poor, President Johnson declares "War on Poverty." Important legislation includes Economic Opportunity Act, Civil Rights Act, Medicare, Medicaid, Elementary and Secondary Education Acts, and Voting Rights Act. Health Manpower Act of 1968 enlarges scholarship & loans and increases funding for medical school construction. In 1965 Canada Assistance Act (welfare), and Canada Pension Plan pass. Medicare passes in 1966.	Rising costs of medical care mobilized American capitalism. The Washington Business Group on Health, representing 200 of the largest corporations, worked with state and academics to study cost issue. Fee for service medicine was blamed "as a major incentive to increase care past the point of need" (Krause 1996: 44).	Expertise and control inherent in medicine challenged by community participation norms of community mental health and general health centers funded by state. Physicians lose public esteem by their bitter opposition to Medicare and Medicaid. Doctors are won over by being able to charge "usual and customary charges" (Krause 1996: 43). Income for physicians and cost of programs quickly rise.

\*Sources: (Burner, Fox-Genovese, and Bernhard 1991; Chernow 1998; Fishbein 1947; Krause 1996; Lii 1987; Riendeau 2000; See 2001; Shryock 1936; Starr 1982; Stevens 1989; Taylor 1974; Zinn 1980). Hill-Burton Free Care Program website accessed August 17, 2003: <http://www.hrsa.gov/osp/dfer/about/aboutdiv.htm>

**Table 3.1 Total Expenditures on Health, % GDP,<sup>a</sup> Selected OECD Countries, 1960-2001<sup>b</sup>**

Year	Australia	Canada	Germany	Sweden	United Kingdom	United States
1960	4.1	5.4				5
1970		7	6.2	6.7	4.5	6.9
1980	7	7.1	8.7	8.8	5.6	8.7
1990	7.8	9	8.5	8.2	6	11.9
1991	8	9.7		8.1	6.5	12.6
1992	8.1	10	9.9	8.3	6.9	13
1993	8.2	9.9	9.9	8.6	6.9	13.3
1994	8.2	9.5	10.2	8.2	7	13.2
1995	8.2	9.2	10.6	8.1	7	13.3
1996	8.4	9	10.9	8.4	7	13.2
1997	8.5	8.9	10.7	8.2	6.8	13
1998	8.6	9.1	10.6	8.3	6.9	13
1999	8.7	9.1	10.6	8.4	7.2	13
2000	8.9	9.2	10.6	8.4	7.3	13.1
2001		9.7	10.7	8.7	7.6	13.9

a. Gross Domestic Product (GDP) measures the values of all goods and services within a country within a specific period of time. "The 'health to GDP ratio' is one of the most closely followed indicators of the extent to which a nation devotes productive resources to health (Canadian Institute for Health Information 1999: 10).

b. Source: OECD Health Data 2003

**Table 3.2 Total Expenditures on Health Per Capita, US\$ PPP, Selected OECD Countries, 1960-2001\***

Year	Australia	Canada	Germany	Sweden	United Kingdom	United States
1960	87	107				144
1970		255	223	270	144	347
1980	658	709	824	850	445	1055
1990	1300	1674	1600	1492	977	2738
1991	1379	1812		1460	1029	2957
1992	1445	1898	1870	1501	1184	3165
1993	1528	1955	1878	1550	1208	3357
1994	1614	1992	2047	1552	1271	3500
1995	1778	2115	2263	1680	1330	3654
1996	1870	2093	2340	1779	1440	3792
1997	1982	2187	2465	1855	1516	3939
1998	2079	2288	2520	1903	1563	4095
1999	2224	2433	2615	2053	1704	4287
2000	2350	2580	2780	2195	1813	4540
2001		2792	2808	2270	1992	4887

\*Source: OECD Health Data 2003

**Table 3.3 Aggregate Amounts of Health Expenditures by Type of Expenditure, United States, Selected Years 1980-2001<sup>a</sup>**

(Amounts in Billions of U.S. Dollars)

Type of Expenditure	1980	1990	1995	1999	2000	2001	Average Annual Growth 1960-1980	Average Annual % Change 1999-2000	Average Annual % Change 2000-2001
Hospital Care	101.5	253.9	343.6	393.7	416.5	451.2	12.8	5.8	8.3
Physician and clinical services	47.1	157.5	220.5	270.2	288.8	313.6	11.5	6.9	8.6
Dental Services	13.3	31.5	44.5	56.4	60.7	65.6	10.0	7.7	8.0
Other professional services	3.6	18.2	28.5	36.7	38.8	42.3	11.7	5.8	9.1
Other personal health care	3.3	9.6	22.9	33.6	36.7	40.9	8.6	9.1	11.5
Home health care	2.4	12.6	30.5	32.3	31.7	33.2	20.6	-1.8	4.5
Nursing home care	17.7	52.7	74.6	89.6	93.8	98.9	16.4	4.7	5.5
Prescription Drugs	12.0	40.3	60.8	104.4	121.5	140.6	7.8	16.4	15.7
Other medical products	13.7	33.1	39.7	47.7	48.9	50.1	9.4	2.7	2.4
Government administration and net cost of private health insurance	12.1	40.0	60.4	73.2	80.7	89.7	12.2	10.3	11.2
Government public health activities <sup>b</sup>	6.7	20.2	31.4	40.9	44.1	46.4	15.3	7.7	5.3
Research <sup>c</sup>	5.5	12.7	17.1	23.5	29.1	32.8	10.9	24.1	12.7
Construction	6.8	13.7	15.5	17.6	18.6	19.2	10.0	5.8	12.7
<b>Total Health Expenditures</b>	<b>245.8</b>	<b>696.0</b>	<b>990.1</b>	<b>1,219.7</b>	<b>1,310.0</b>	<b>1,424.5</b>	<b>11.7</b>	<b>7.4</b>	<b>8.7</b>

a. Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed August 13, 2003 <http://www.cms.gov>

b. This figure includes personal care services by government public health agencies.

c. Research and development activities of drug companies and other manufacturers and providers of medical equipment are excluded from research expenditures. These research expenditures are implicitly included in the expenditure class which the product falls, in that they are covered by payment received for that product.

A more detailed exploration of similarities and differences between the medical care systems of the United States and Canada will be found in Chapter Six. National health care spending in the United States increased from \$41 billion in 1965<sup>125</sup> to \$1,424.5 billion (or 1.4 trillion) in 2001. Table 3.3 indicates component parts of the medical industrial complex by illustrating the growth by sector of national health expenditures in the United States.

As the “United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves,”<sup>126</sup> the outlay for the Department of Health and Human Services was \$426.8 billion, comprising 22.9% of the federal budget in Fiscal Year 2001 (Centers for Medicare and Medicaid Services 2002: 24). With 11 operating divisions, more than 300 programs, and providing 60,000 grants per year, this department employs 65,000 people. The fiscal year 2003 budget is \$502 billion.<sup>127</sup> Key divisions are listed:

**Table 3.4 Department of Health and Human Services, Key Operating Divisions, Number of Employees and FY2003 Budgets\***

Name	Year established	FY 2003 Budget \$ billions	Number of employees
Centers for Medicare & Medicaid Services (previously Health Care Financing Administration)	1977	\$413	4,661
Administration for Children and Families	1991	\$47.5	1,512
National Institutes of Health (previously Hygienic Laboratory)	1887	\$27.2	17,693
Health Resources and Services Administration	1982	\$7.1	1,937
Centers for Disease Control and Prevention	1946	\$6.8	8,668
Indian Health Service	1924	\$3.5	14,961
Substance Abuse and Mental Health Services Administration (previously Alcohol, Drug Abuse and Mental Health Administration)	1974	\$3.2	588
Food and Drug Administration	1906	\$1.7	10,479
Administration on Aging	1965	\$1.4	124
Agency for Healthcare Research and Quality	1989	\$309 M	294

\*Source: United States Department of Health and Human Services website, accessed August 8, 2003 <http://www.hhs.gov>

The phenomenal growth of “Great Society” entitlement programs such as Medicare and Medicaid is shown below.

**Table 3.5 Indicators of Growth of Medicare and Medicaid**

	1966	1967	1980	1990	2000	2001	2002
Medicare <sup>a</sup> Enrolment #		19.5 M.				40 M.	40.4 M.
Medicare \$ Expenditures		4 B. <sup>b</sup>	35 B \$	109.7B	219B	242.4 B	
ESRD <sup>c</sup> Enrolment #			Less than 67,000		292,000		
ESRD Facilities #			999		3,787	3,991	
Medicaid <sup>d</sup> Enrolment #	4 M.				33 M.	34.3 M of which 17 M are children	
Medicaid \$ Expenditures	Less than 1 B.		25.8 B.	72.5 B.	208 B.	227.9B	

- a. Unless indicated otherwise, data are from (Centers for Medicare and Medicaid Services 2002).
- b. (Wildavsky 1992: 310)
- c. End Stage Renal Program (ESRD) Program has been called “the most unusual health program under Medicare’s purview” (Weiss 1997: 131).
- d. Medicaid data for 1966 and 2000 (Klemm 2000: 105).

Since its inception, numbers of beneficiaries, number of facilities such as those caring for end stage renal disease, and expenditures have grown exponentially since 1966.

As outlined in Exhibit 3.2, expenditures for the National Institutes of Health may be traced from \$300 for a room laboratory within the Marine Hospital Services in 1887 to a NIH budget of \$8 million in 1947, \$1 billion in 1966, onto a FY2003 budget of \$27.2 billion. This ferocious growth, including a doubling of the NIH budget from 1998 to 2003, is shown in Table 3.6.

**Table 3.6 National Institutes of Health, Total Appropriations for Selected Years, 1938-2002\***

(Amount in thousands of dollars)

Year	Total
1938	464
1940	707
1950	43,480
1960	331,910
1970	1,061,007
1980	3,428,935
1990	7,576,352
1991	8,276,739
1992	8,921,687
1993	10,335,996
1994	10,955,773
1995	11,299,522
1996	11,927,532
1997	12,740,843
1998	13,647,843
1999	15,652,386
2000	17,793,587
2001	20,298,269
2002	23,256,571

\*Source: Data from National Institutes of Health website, accessed August 13, 2003  
<http://www.nih.gov/about/almanac/appropriations/part2.htm>

Within these large expenditure numbers, one may trace<sup>128</sup> the escalation of financial support for specific institutes and their areas of interest over time in Table 3.7.

Clearly, diseases and organs are the big winners in this peer-review lottery.<sup>129</sup> This could be interpreted as a validation of the effectiveness of Flexner's advocacy for laboratory medicine as well as a tracing of the ascent of the logic of monotheistic biomedical culture. This nexus of science, money, and state defines health and health care daily and with more resources. FY2003 Amended President's Budget of \$27,343.3 million is a 16.1% increase over FY2002 actual budget of \$23,558.9 million. The President's Budget for FY 2004 includes a 1.8% increase for the National Institutes of Health to \$27,892.8 million (National Institutes of Health 2003: 1).



**Table 3.7 Growth of National Institutes of Health by Trajectory of Appropriations for Selected Years<sup>a</sup>**

The following were selected from a total of 27 Institutes and Centers that comprise the National Institutes of Health.

Name	(Amounts are in thousands)	Start Year	First year \$	1960	1980	2000	2002
National Cancer Institute		1937	400	91,257	999,869	973,146	1,248,093
National Eye Institute		1968	22,828		112,989	450,300	581,191
National Heart, Lung, and Blood Institute		1948	2,835	62,237	527,488	2,029,424	2,575,197
National Human Genome Research		1989	59,538			335,527	429,312
National Institute on Aging <sup>b</sup>		1974	19,288		69,988	686,479	893,130
National Institute on Alcohol Abuse and Alcoholism <sup>c</sup>		1970	176,619			292,369	384,071
National Institute of Allergy and Infectious Diseases		1948	5,501	34,054	215,364	1,778,038	2,346,039
National Institutes of Arthritis and Musculoskeletal and Skin		1986	138,713			349,968	448,699
National Institute of Biomedical Imaging and Bioengineering		2000	119,951				119,951
National Institute of Child Health and Human Development		1962	34,000		208,953	858,291	1,113,087
National Institute on Deafness and Other Communication D.		1988	94,166			263,771	341,965
National Institute of Dental and Craniofacial Research		1948	1,733	10,019	68,303	268,811	343,149
National Institute of Diabetes and Digestive and Kidney Diseases		1948	4,064	46,862	341,206	1,141,476	1,466,380
National Institutes on Drug Abuse		1973	403,806			685,781	887,733
National Institute of Environmental Health Sciences		1969	24,298		83,893	442,449	646,846
National Institute of General Medical Sciences		1962	104,460		312,468	1,354,420	1,725,139
National Institutes of Mental Health		1949	4,250	67,470		973,146	1,248,093
National Institutes of Neurological Disorders and Stroke		1950	1,562	41,487	241,966	1,029,376	1,327,780
National Institute of Nursing Research		1986	20,000			89,522	120,428
National Library of Medicine		1956	18,160		43,979	214,068	277,272
National Center for Complementary and Alternative Medicine		1992	68,390			68,390	104,592
National Center on Minority Health and Health Disparities		1993	130,096				157,742

a. Source: National Institutes of Health data accessed August 8, 2003, <http://www.nih.gov/icd/>

b. National Institute on Aging was formerly part of the National Institute on Child Health and Human Development.

c. National Institute on Alcohol Abuse and Alcoholism first year funding is for 1993 as it was formerly part of ADAMHA (NIMH, NIDA, and NIAAA).

Moving back in time from this overview of the growth of the National Institutes of Health, one can consider the specific impact of NIH funding on medical schools. Not coincidentally, by 1930 “the faculties in the best schools had become scientific investigators, as indeed they have remained” (Stevens 1971: 358). By 1955, medical schools were receiving one-third of their income from outside research grants, primarily the federal government (Stevens 1971: 359). Rosemary Stevens argues “by 1960 the medical schools had become in large part arms or branches of NIH” (1971: 360). Responding to “an apparently never-ending stream of federal wealth,” principal investigators built up “powerful baronies” concentrating on “relatively esoteric realms of research” (Stevens 1971: 360). Based on “peer-group definitions of excellence,” grants flowed toward those institutions that were most highly regarded. Harvard Medical School received \$11.9 million in Fiscal Year 1968 while Meharry Medical School and Howard Medical School (serving primarily black students) received less than \$400,000 each (Stevens 1971: 370). Interestingly enough, the “eternal academic elite” (Greenberg 2001: 38) have remained fairly consistent from 1980 to 1995 with Johns Hopkins as in days of old leading the pack.<sup>130</sup> Allocating financial resources to institutions deemed to be “excellent” based on “scientific peer review” to those who most resembled the reviewers<sup>131</sup> systematically rewarded vertical problem definitions and technical solutions while hiding structural racism, sexism, and classism. Attempts to increase representation through such programs as the National Science Foundation’s Experimental Program for the Stimulation of Competitive Research have been criticized as “scientific welfare” unfair to “the very best research” (Greenberg 2001: 39).<sup>132</sup>

Greenberg makes a compelling case that scientists, even though “a profession built on numeracy and dedicated to accuracy” are “not the most reliable commentators on the historical, political, and financial realities of their profession” (2001: 77). Irrespective of actual expenditures, researchers from every scientific discipline look

longingly back to some Golden Age when their work was appreciated and properly funded. Even in times when funding is at a historic high, as in 1998, the head of communication and public liaison for the National Institutes of Health warned that public support is based “on a partial—and only partial—recognition of the link between research and better health. Consequently it may not be reliable over time” (Greenberg 2001: 208). Greenberg argues that funding for health research has indeed been reliable over time because “biomedical politics eludes budget control” (2001: 197). In addition to the rewards of votes and donations for supporting health and the health care industry as well as status markers such as awards from grateful professional associations and NIH buildings given politicians’ names, there is a “very personal relationship that Congress has with NIH:”

“There’s not much you can do about NIH,” Dr. Allan Bromley, White House Science adviser in the Bush administration, candidly acknowledged to me, “It really reflects the fact that every member of Congress knows that sooner or later they’re going to be on a stainless steel gurney with an M.D. looking at them, and their view is it doesn’t pay to make M.D.’s real unhappy” (Greenberg 2001: 197).

### Commerce at the Stern: Protecting the “Sacred Trust” of Entrepreneurial Medicine

That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid.... Scandalized voices murmur that these operations are necessary. They may be. It may also be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the housebreaker the judges of that (Shaw 1980: 7).

George Bernard Shaw was not disparaging physicians. He was just arguing for their humanity by saying “as to the honor and conscience of doctors, they have as much as any other class of men, no more and no less” (1980: 8). Just as physicians have been

known to confuse health with medicine,<sup>133</sup> they have also been known to conflate their interests with those of their patients as Shaw clearly realized in his attack on fee-for-service medicine.

One of the controversies inherent in Flexner's Report for many physicians was his recommendation that academic faculty at medical schools be appointed full time with curtailed private practice. A leaked confidential report prepared by Abraham Flexner for Frederick Gates on Johns Hopkins suggested that clinicians had sold out:

As contrasted with the instructors on the laboratory side, the clinical staff has been on the whole less productive and less devoted...The clinicians have with very few exceptions proved too easy victims to the encroachment of private practice. Not only has productive work been sacrificed to private professional engagements—routine teaching and hospital work go by the board when a large fee is in prospect. Classes are turned over to subordinates in order that the chief may leave town to see patients, not because they are scientifically interesting, but because they are pecuniarily worth while (Bliss 1999: 381-382).

Another complaint that Flexner expressed was that the private wards had become "in large measure high-priced sanitariums for the well-to-do private patients of the prominent clinicians connected with the hospital and medical school" (Bliss 1999: 381). As Johns Hopkins staff considered the implications of moving to a salaried basis, Bliss described the institutional atmosphere as "engulfed in meetings, gossip, bitterness, and intrigue" (1999: 383). Surgeon, faculty member, and "Christian philanthropist" Howard Kelly<sup>134</sup> was "incensed that Flexner was proposing 'a system of peonage similar to nothing else in the world' for the announced purpose of counteracting money making" (Bliss 1999: 383).

The rhetoric of peonage, slavery, and constriction of freedom (as well as the phenomenon of meetings, bitterness, and intrigue) will become familiar to anyone reviewing the following historical events in Exhibit 3.5, Selected Examples of Organized Medicine Advocating Entrepreneurial Medicine in the United States as Evinced in Stance Against "Socialized Medicine" and Exhibit 3.6, Selected Events in the Context

and Trajectory of the Doctors' Strike of 1962 in Saskatchewan, Canada. These two examples are significant for both their political economy and discursive dynamics of entrepreneurial medicine. Before noting some of the more salient aspects of these particular examples, similarities between the "public goods" attributes of education and health care may be noted.

Badgely and Wolfe's observation that many of the same arguments used against universal education have also been utilized against universal health care is supported by Exhibits 3.5 and 3.6. In 1830 in the *Philadelphia National Gazette*, the following arguments were raised in opposition to tax-financed education for all children:

Public coverage will remove the enterprise and competition of individuals. Political bureaucracy will be rampant. It is socialism. It will destroy initiative and ambition. Standards will be lowered. It is foreign to our country. Requiring people to pay under universal coverage is dangerous and there is no confidence in compulsory equalizations. If all are covered through tax-supported funds, languor decay and discontent will ensue (Badgely and Wolfe 1967: 149).

Analogies between health care and education will reappear in Chapter Eight as purveyors of boutique physician practices argue that discretionary spending on luxury medical care is equivalent to the market for private education.

**Exhibit 3.5 Selected Examples of Organized Medicine Advocating Entrepreneurial Medicine in the United States as Evinced in Stance Against “Socialized Medicine”**

Date	Narrative of Organized Medicine Advocating Entrepreneurial Medicine
1904	Doctors complain that free dispensaries are giving aid to wealthy and poor alike. They charge that affluent citizens crowd out the poor and labeled one site in New York as the “Diamond Dispensary” (Burrow 1977: 111). Physicians lament fees forgone that “deprived the profession of \$780 in one year” and opine that the poor “obtain vastly more than they have a right to expect...vast sums of money are wasted yearly on worthless and undeserving persons” (Starr 1982: 182).
1910	Boston Medical Society protests that city hospital is allowing “indiscriminating medical charity” (Burrow 1977: 112)
1911	Committee on Dispensary Abuse of the Medical Society of the County of New York commissions survey. Social work researcher finds 90% of sample are deserving of free treatment and that average poor people are struggling to meet basic needs to survive (Burrow 1977: 112).
1911	Committee on Contract Work in New York urges “antagonistic measures if persuasion fails” greater than what “we have done (to) the advertising quack” against any physician engaged in contract work (Burrow 1977: 131).
1917	After initial support by AMA Committee on Social Insurance, support for compulsory health insurance splits with academic doctors favoring it and “practicing physicians” against it. Anti-German sentiment linked to WWI results in health insurance being called “undemocratic” because of origins in Germany. After Russian Revolution, some AMA leaders brand national health insurance as “a detestable form of socialism” (Wolinsky and Brune 1994: 18).
1928	Discussion within House of Delegates of the AMA about “the manner in which the federal government had begun socialization of medicine through the expansion of care given to veterans.” (Fishbein 1947: 374)
1930	Judicial Council of the AMA gives opinion that contract medicine “is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served” (Fishbein 1947: 385).
1932	Committee on Costs in Medical Care, including past president of AMA, Ray Lyman Wilbur, recommend group practice for doctors and voluntary health insurance for patients. In response, JAMA dismisses group practice as a system of “medical soviets.” “The alignment is clear—on the one side, the forces representing the great foundations, public-health officialdom, social theory—even socialism and communism—inciting to revolution; on the other side, the organized medical profession of this country, urging an orderly evolution” (Harris 1966: 8)

Date	Narrative of Organized Medicine Advocating Entrepreneurial Medicine
1934	House of Delegates of the AMA passes a "statement of principle" that the immediate cost of medical service should be borne by the patient. "Any system of medicine that offers complete coverage and relieves the recipient of making any direct contribution for his own medical care will lower his sense of responsibility for his own health and that of his family and will eventually depreciate the quality of medical services he receives" (Harris 1966: 16)
1935	AMA affiliated medical societies organize a boycott against the Borden Milk Company to get at the Milbank Fund, which it funded and supported compulsory health insurance. Milbank fired its director and muted its program on health (Wolinsky and Brune 1994: 21)
1938	AMA speaks often of the virtues of "free enterprise medicine" and opposes "corporate medicine" which is any form of work for a salary, whether it be medical school, research foundation, hospital, government service, or industry. Seven doctors working on salary for Group Health Association of Washington are denied hospital privileges for themselves and their patients and boycotted. AMA and District of Columbia Medical Society are indicted for antitrust violations. Supreme Court upholds conviction when conspiracy proven to exist (Harris 1966)
1939	National Health Bill introduced which would provide federal funds to match state allocations for public health programs. While it did not propose any form of health insurance, the AMA charged it provided "supreme federal control" over medicine and that it would lead insidiously to "a complete system of tax-supported governmental medical care." Dr. Fishbein, in a speech before the Association for Social Security, calls it "another step toward the breakdown of American democracy." He also told them that "the inability of the poor to obtain medical services was not a problem for the medical profession but one for social workers, who had 'failed miserably' in that regard" (Harris 1966: 23-24) National Physicians' Committee for the Extension of Medical Service (NPC) whose aim was to protect the status quo founded to thwart National Health Bill.
1942	NPC mobilizes against Wagner-Murray-Dingell proposal to provide comprehensive medical care by distributing 15 million copies of a pamphlet that warned the issue was "human rights opposed to State slavery." The NPC also provided posters for display in doctors' waiting room. "It showed an elderly woman timidly facing a wrathful doctor (or perhaps it was a wrathful bureaucrat in doctors' clothing) who was saying, "Make it snappy, sister." The text explained, "The doctor can't sit listening to your tale of woe. He's not a private physician. He works for the government, not you. You're just one of the people assigned to him by the political overseer...So snap into it, comrade!"(Harris: 29)
1945	California Governor Earl Warren sends a compulsory health insurance bill to the state legislature. "To meet this new threat of 'socialized medicine'—a term that Governor Warren called an 'ideological blackjack'—the California Medical Association hires a local public relations firm called Whitaker & Baxter. Their first move was advise the doctors that "you can't beat something with nothing" so championed support for "voluntary" (Blue Cross, Blue Shield and commercial health insurance plans) rather than "compulsory" insurance. California Medical Association spends \$250,000 on massive campaign and wins, with the help of businessmen friendly to their cause. (Harris 1966: 31-33)

Date	Narrative of Organized Medicine Advocating Entrepreneurial Medicine
1945	Response to new version of national health program bill introduced by President Truman attacked by AMA. Editorial in JAMA proclaims: "No one will ever convince the physicians of the United States that the Wagner-Murray-Dingell bill is not socialized medicine. By this measure the medical profession and the sick whom they treat will be directly under political control...Through this measure competent young men who would enter the medical profession will be forced to seek other fields of action still remaining under our democracy which still permit the exercise of individual initiative and freedom of thought and action. By this measure doctors in America would become clock watchers and slaves of a system" (Fishbein 1947: 485-486).
1946	Senator Taft introduces bill that would provide matching funds to states for medical care for those who could pass means test to prove they were indigent. AMA says it amounted to socialized medicine. (Harris 1966: 35-36)
1948	NPC sends out a letter to doctors and clergy that "started out 'Dear Christian American,' and then went on to imply that certain non-Christians whom it didn't identify, were leading the fight for socialized medicine. And the reader was warned to be prepared for the inevitable results of national health insurance—free love, birth control, and a dangerously high birth rate" (Harris 1966: 38).
1949	AMA launches "one of the first nationwide political-public relations campaigns in U.S. history" (Wolinsky and Brune 1994: 24). Whitaker & Baxter produce 15 page pamphlet entitled "The Voluntary Way is the American Way" filled with allusions to Nazi Germany and Stalin. Other propaganda included 70,000 posters of a sentimental doctor-family bedside scene with the text: Keep Politics Out of This Picture! When the life—or health of a loved one is at stake, hope lies in the devoted service of your Doctor. Would you change this picture? Compulsory health insurance is political medicine. It would bring a third party—a politician—between you and your Doctor. It would bind up your family's health in red tape. It would result in heavy payroll taxes—and inferior medical care for you and your family. Don't let it happen here!"(Harris 1966: 44-45) AMA asserts that the "U.S. system is the best in the world" and reiterates that Truman's program of "socialized medicine" would turn doctors into slaves. Whitaker and Baxter succeed in redefining the issue from "greater health security" as Truman defines it, to a battle over "socialized medicine", as the AMA prefers (Wolinsky and Brune 1994: 25). From 1949 to 1952, AMA campaign against federal health insurance cost \$4,678,000 (Stevens 1971: 426).
1957	AMA sets up Joint Council to Improve the Health Care of the Aged in response to Forand Bill. Council's Chief concluded that aged were already getting top notch care, better than younger people. Critics say Council's real purpose is to gather allies to fight Forand Bill with a united front. Testifying against Forand Bill, AMA argues, "it would legislate the aged into a permanent state of dependency." State medical associations threaten to disobey law if passed (Harris 1966: 74, 81-82).
1959	AMA sends legislative alert to members about the Forand Bill warning that "this legislation would establish a dangerous and gravely harmful precedent that would undermine the doctor-patient relationship and would open the doors to the eventual socialization of medicine" (Harris 1966: 94) At 1959 hearings, Dr. Larson testifying for AMA says "since 1900 better medical care has increased the life expectancy of the average American by 20.5 years" and that "American doctors had created the problem and American doctors would solve it" (1966: 95).



Date	Narrative of Organized Medicine Advocating Entrepreneurial Medicine
1962	Ronald Reagan cuts a 331/3 rpm record entitled "Ronald Reagan Speaks Out Against Socialized Medicine" for the AMA. Reagan warns listeners, "One of the traditional methods of imposing statism or socialism on a people has been by way of medicine." If Medicare passes, he said, "one of these days you and I are going to spend our sunset years telling our children and our children's children what it once was like in America when men were free." This record was used as part of "Operation Coffee Cup"--thousands of doctors' wives would urge their friends to write letters to Congress after listening to the record (Harris 1966: 139).
1965	AMA opposes Medicare as "dangerous venture by the Federal Government into the field of health care...Government regulation and control which would be established under this bill is not compatible with good medicine" (Wolinsky and Brune 1994: 28). AMA organizes another massive publicity blitz including 30-minute national television program called "Health Care at the Crossroads" and ads entitled "An Open Letter to Our Patients." Five hundred elderly picket AMA convention giving out "An Open Letter to Our Doctors." Nine state delegates introduce separate resolutions calling for boycott of Medicare at AMA Convention (Harris 1966: 206-207) Johnson allowed doctors to set their own fees and help write Medicare's rules in order to placate them.. Average physicians' earnings rose 11 percent due to higher fees and increased number of patients in the first year of 1966. AMA consistently tried to get means tests and extra-billing as "it was the right of the elderly to pay their doctors as much money as they wanted" (Wolinsky and Brune 1994: 48).
1970	Medicare and Medicaid program in "serious financial trouble" due to soaring costs (Wolinsky and Brune 1994: 49).
1983	Concerns about rising costs and fraud continue throughout the 1970s. Elderly are paying \$2.5 billion extra for physician services as 80% of doctor bills exceed Medicare's "reasonable rate." AMA suggests voluntary price freeze in anticipation of push in Congress to legislate cost control. Proposal to ban extra-billing reviled by AMA officials as "public-utility regulation of medicine" and threaten that 60% of doctors would drop out and cripple the system. Congress enacted 15-month freeze on Medicare doctor fees. AMA sued the Department of Health and Human Services complaining that they were the only professionals whose fees were frozen to reduce the federal budget deficit. They also argued that the freeze denied patients the right to select their own doctors because it prevented them from paying the higher fees doctors charged non-Medicare patients. In 1985 a federal judge dismissed the lawsuit as no patients were denied care as a result of the freeze (Wolinsky and Brune 1994: 52-58).
1986	Congress creates Physician Payment Review Commission. Proposed fee schedule causes schism between specialists and family practitioners. American College of Surgeons reaches agreement to negotiate directly with Congress.
1989	Representative Stark launches hearings on "blank check" model of paying doctors. In previous 5 years, Medicare spending on doctors had doubled to \$28 billion. Seniors were paying 15% of income on medical care for out-of-pocket costs, the same as when Medicare began in 1966. Rising costs directly related to volume of services. AMA resists "expenditure targets as "It's rationing, no matter what the hell they say." AMA sets off public relations and lobbying campaign, which included full-page newspaper ad aimed at Congress. It showed a picture of an elderly woman with the caption: "How Do You Tell Someone on Medicare She's an 'Expenditure Target?'" (Wolinsky and Brune 1994: 61-64)

Date	Narrative of Organized Medicine Advocating Entrepreneurial Medicine
1989	AMA solicits contributions of \$200 or more from its members for campaign to discredit Canadian single payer health system. The mailing read: "Unless you want to risk rationing, income caps, reduction of your autonomy, and other burdens of a Canadian-type experience very soon, please help us." Newspaper ads equated Canada with health care in Third World countries. Campaign was said to backfire and AMA stopped ads in February 1990 (Weiss 1997: 39)
1990	Less than one quarter of the 43,000 practicing physicians in New York state will treat Medicaid patients (Weiss 1997: 182).

**Exhibit 3.6 Selected Events in the Context and Trajectory of the Doctors' Strike of 1962 in Saskatchewan, Canada\***

Date	Narrative of 1962 Doctors' Strike in Saskatchewan
1913	Tommy Douglas, child of Scottish immigrants, almost has leg amputated at Children's Hospital in Winnipeg due to osteomyelitis. His leg is saved by Dr. Smith who uses Douglas as a case for teaching demonstrations. Douglas's experiences as a charity patient stay with him during his later political career: "Had I been a rich man's son the services of the finest surgeons would have been available. As an iron moulder's boy, I almost had my leg amputated before chance intervened and a specialist cured me without thought of a fee" (Badgely and Wolfe 1967: 20).
1914	Rural municipality of Sarnia is about to lose its only doctor. Elected officials offer him an annual retainer of \$1,500 as an inducement to stay.
1916-1919	Rural Municipality Act amended to make it possible for municipal councils to collect taxes to pay a doctor a maximum salary of \$5,000.
1916	Farmer driven legislation combines towns, villages, and rural municipalities into "union hospital districts." Union hospital boards levy taxes on property to erect and operate general hospitals.
1921-1930	Municipal doctor plan grows in number from 1 to 32. Access to municipal doctor functions well until people start to move to cities and need portable coverage. Town and city doctors vigorously oppose municipal doctor scheme but they are in minority.
1931	United States's Committee on the Costs of Medical Care praises the municipal doctor plan for its equity, efficiency, primary prevention, and cordial relationships between doctor and patients. They report: "No community in Saskatchewan which has adopted the municipal doctor plan has abandoned it" (Badgely and Wolfe 1967: 9).
1932-1942	Government puts doctors "on relief" by guaranteeing minimum monthly payments of \$50 or \$75 to those working in the most severely affected drought areas. During the Depression, Saskatchewan has fewer doctors per capita than any other part of Canada. In 1931 the physician to population ratio is 1: 1,579 and in 1941 it reaches a trough of to 1: 1,700 (Judek 1964: 27)
1933	First national convention of the Co-operative Commonwealth Federation (CCF) held in Regina. "More Christian than Marxist in its ideology" (Badgely and Wolfe 1967: 5), this party resonates with supporters of the Farmers' Progressive movement, trade-unionists, socialists, intellectuals, and eventually the public.
July 1, 1935	Riot in Regina erupts for over three hours when police attempt to arrest strike leaders. One city detective killed, more than 100 citizens and police injured, with half requiring hospitalization.
1937	Two-thirds of the people in the province are on relief. A family of five receives monthly support of \$20.20. Dependent on only one commodity, wheat, Sask.'s population suffers more acutely than those of any other province.

Date	Narrative of 1962 Doctors' Strike in Saskatchewan
1939	Norwegian immigrant, Matt Anderson, organizes McKillop municipal insurance program covering visits to a doctor of patients' choice, funded by taxes. This is the forerunner of the regional Swift Current plan.
1939	Co-operatively sponsored medical insurance plan set up by consumers in Regina immediately opposed by Regina doctors who form their own insurance scheme. Co-op has 1,5000 families as members and applications from 8 doctors to work as salaried staff in their clinic. After pressure from their peers, all 8 applicants withdraw their applications and no local doctors are willing to work for the clinic. Members of the co-op are warned; "you're running up against the toughest wall you ever struck when you start opposing the doctors" (Badgely and Wolfe 1967: 16).
1942	Legislature votes in favor of "a further extension of state-aided hospitalization and medical services" as soon as finances permit. Doctors' association and most doctors support state-aided health insurance as they have experience with the depression and funding from governments.
1944-1961	CCF wins provincial election to become the first socialist government in North America. Tommy Douglas promises that his party will set up hospital, medical, and dental services "available to all without counting the ability of the individual to pay." Douglas becomes Minister of Health as well as Premier of the province (Badgely and Wolfe 1967: 17).
1946	First district wide medical insurance program starts in economically depressed Swift Current. A family payment of \$48 per year and a land tax covers 50,000 people (Clarke 2000: 247) over 10,000 square miles. Number of doctors increases from 19 in 1946 to 41 in 1960 (Badgely and Wolfe 1967: 19).
1947	Saskatchewan Hospital Services Plan starts—by end of year, 93% of population are covered for hospital care (Clarke 2000: 247).
1950	"There is little doubt that the Canadian medical profession in general, and the Saskatchewan profession in particular, would have supported government-sponsored health insurance to pay doctors' bills, at least until the early 1950s" (Badgely and Wolfe 1967: 26).
1951-1959	Medical profession in Saskatchewan reverses its position on government-run health insurance. Doctors' own insurance plans now cover about 40% of the population. Doctors are increasingly more urban and many of the physicians from the Depression era are now gone. Some of the replacements are disaffected doctors from England fleeing the introduction of the National Health Service there. Nationally, between 1953 and 1961 46.2% of all physicians who immigrate into Canada are nationals from the United Kingdom (Judek 1964: 39).
1955	Some doctors campaign against implementation of regional medical care programs in two areas of province and win.
1959	Douglas announces the government's position on "Prepaid Medical Care." Five principles are 1) prepayment principle 2) universal coverage 3) high quality of service 4) public administered responsible to the legislature and 5) must be in a form acceptable both to those providing and those receiving services.

Date	Narrative of 1962 Doctors' Strike in Saskatchewan
1960 Election Campaign	Main plank for the CCF party election platform was "Prepaid Medical Care" for this year's provincial election. Medical profession aligns with Chamber of Commerce and Liberal Party against CCF. Many of the same tactics of the American Medical Association are employed including use of public relations firms financed by \$100 assessment of each doctor, "key man" responsible for a cell of doctors, and exclusion of medical heretics from the communication system. Canadian Medical Association contributes an additional \$35,000 to educate the public about the evils of Medicare. Publicity kits were distributed to doctors with the reminder: "The concept of universal medical coverage is not new and the approach by government to seek support is just the same as it was when first enunciated by Karl Marx in his Communistic Theories of the last century (p. 31). Ranting against the compulsory aspect of the prepaid plan, other rhetoric in the publicity kits includes: "Compulsion is an evil word. It carries with it the aroma of medieval times when slavery was an accepted standard of living; when a minority group dictated its will upon the masses and used every means of cruelty known to men—the whip and the rod—to make sure slaves toed the line. (p. 32-33).
1960 Election Campaign	Catholic women are warned: " A government controlled plan offers a latent but potential threat to certain dogma and views of the Catholic Church relating to maternity, birth control, and the state." In "Women and Their Personal Doctor" women are told that under the new plan, they might have to go to a mental hospital or to a psychiatric clinic "during a woman's change in life" when she is "subjected to many disturbances which she does not understand" (p. 33).
1960 Election Campaign	Four days before election, a full page ad signed by 243 doctors (86 of which are teachers at the College of Medicine, University of Saskatchewan) appears: "Compulsory state medicine has led to mediocrity and a poorer quality of care everywhere it has been put into practice" (p. 34-35). Individual doctors find it difficult to dissent because the College of Physicians and Surgeons of Saskatchewan sets standards, has licensing and disciplinary authority as well as trade-union functions.
June 8 1960	On election day, CCF wins 38 of 54 seats in legislature. Editorial cartoon in the <i>Saskatoon Star-Phoenix</i> newspaper shows "Premier Douglas as a Heap Big Medicine Man standing over vanquished Indian foes" while editorials for this Liberal Party paper continue to agitate for a voluntary plan (p. 35).
Post 1960 election	Many doctors are circumspect about the election results but there are a few exceptions. One warns that the shadow boxing has ended—"the medical profession of Saskatchewan was now out of the gym and into the ring." A physician who was a director of a large insurance company and a defeated Conservative party candidate complained: "I still think it's unfair...a definite violation of the rights of Saskatchewan citizens" (pp. 35-36)
September 1961	Medical Care Advisory Planning Committee issues its Interim Report. Majority report recommends universal coverage with comprehensive medical service benefits run by a public commission with personal premiums to be paid by those who can afford do so. The minority report was signed by the three physicians representing the organized medical profession and the Chamber of Commerce. They recommend health

Date	Narrative of 1962 Doctors' Strike in Saskatchewan
September 1961 continued	insurance through existing insurance agencies with government subsidies for the poor. The dissenting report by the representative of the Saskatchewan Federation of Labour supported a medical plan administered through the Department of Public Health and urged salaried payments for doctors (p. 36-37).
Nov. 17, 1961	Recommendations from the majority report form basis for the Saskatchewan Medical Care Insurance Act of 1961, which received royal assent on this date. Medical profession argues that there was insufficient time between release of Interim Report and special session of provincial parliament that passed the legislation. Although six of the twelve members of the Medical Care Advisory Planning Committee were physicians, doctors argue there was "little or no consultation with the medical profession" (p. 39)
1961	At their annual meeting in an open vote, physicians vote almost unanimously to refuse to cooperate with implanting the new Act. In the <i>Saskatchewan Medical Quarterly</i> a physician writes "no labour in the country would accept employment under these terms—this would amount to slave service" (p. 40)
1961	Tommy Douglas leaves provincial politics to become the national leader of the New Democratic Party (NDP). Woodrow Lloyd becomes the new Premier and a new Minister of Health, William Davies, with a trade-union background is appointed by Premier Lloyd.
Nov. 28, 1961	Minister of Public Health, William Davies, telephones president of the doctors' organization, Harold Dagleish, to invite dialogue. From November 1961 to July 1962 the government of Saskatchewan remains committed to two basic principles: the right of a democratically elected government to collect taxes to pay doctors' bills, and coverage of the entire population. The medical profession and its supporters wage an active campaign to oppose these principles (p. 42).
Dec. 29, 1961	Minister Davies receives letter from Dr. Dagleish emphasizing the resolution of non-cooperation but letter does not mention another resolution from the same meeting that authorizes negotiations if advisable.
Late March 1962	Doctors are repeatedly invited and consistently refuse to meet with the provincial government or the newly formed Medical Care Insurance Commission until late March. Commission writes directly to all the doctors in the province after overtures to their representatives are rejected. This action is interpreted by the doctors as "attempting to test the unity of the profession." Some of the replies that the Commission received indicated that they thought of their elected medical representatives as trade union negotiators: For example, "as a member of what amounts to a trade union, I must refer you to my negotiating body" (p. 44)
April 11, 1962	Negotiations between physicians and government break down. Convinced that the doctors will do anything that they can to subvert the law, including harassment of patients, the government amends the medical care act to increase protection for the beneficiaries. This infuriates the doctors.

Date	Narrative of 1962 Doctors' Strike in Saskatchewan
May 3-4, 1962	<p>Approximately 600 of the province's 900 doctors close their offices for two days to attend an "emotionally charged" meeting in Regina. A key spokesperson receives "the loudest applause" when he says that "never since the days of Charles II has there been such legislation reversing the civil rights and liberties of citizens." (p. 47) Premier Lloyd addresses this meeting to boos and hisses. Part of Lloyd's speech includes: "As patients, we are perfectly willing to place matters involving medical judgments entirely in the hands of a highly-skilled group, such as you are. In enacting the Medical Care Insurance Act, however, we have said that we, as consumers of medical services, and as taxpayers, have a right to a say in how we pay our medical bills. We have a right to construct an administrative agency, responsible to us, to arrange for such payment. Medical care is not an optional commodity—it is a necessity. When medical services are needed they should not, in the interests of each of us, be denied to any of us. When a commodity or service is essential our society has long since accepted that consumers have a legitimate right to a voice in making the essential governing decisions in such matters" (p. 49). Following Lloyd's address, Dr. Dalgleish asked those to stand who would refuse to act under the Medicare plan and 545 of the 550 present stood and applauded.</p>
May 9, 1962	<p>Premier Lloyd outlines his government's view of the fundamental issue on television: "The issue is whether the people of Saskatchewan shall be governed by a democratically elected legislature responsible to the people, or by a small, highly organized group. The people of Saskatchewan have been served notice by this organization. The notice is that, until we repeal the Medical Care Insurance Act or unless the group is permitted to ignore the Act of a duly constituted government, the people of the province will be punished by curtailment of medical services" (p. 56). Public demonstrations in favor of Medicare are discouraged by the government in order to prevent violence (p. 79).</p>
Mid May 1962	<p>All practicing doctors are supplied with two copies of a sign to be posted in their offices: "To our patients This office will be closed after July 1, 1962 We do not intend to carry on practice under the Saskatchewan Medical Care Insurance Act." Doctors also receive a "personal letter which you many wish to send to your patients" that reinforces that the office "will stay closed until the Government will allow me to treat you, as I have in the past, without political interference or control. You will appreciate that I am deeply concerned about taking what must seem to you to be a drastic step. Unfortunately, the attitude of Government leaves me with no other choice." At the end of the letter, patients are urged to contact their elected representatives. "It is only in this way Government will be forced to abandon its plan to institute political control of doctors and patients" (pp. 53-54).</p>
May 1962	<p>Keep our Doctors Committee (KOD) organizes petitions and rallies. It is portrayed as a grassroots campaign of concerned mothers but is orchestrated by professional and business elites as well as political opponents of CCF government. The government of Saskatchewan, "hoping for the best and preparing for the worst" starts to recruit doctors from England, other parts of Canada, and the United States in anticipation</p>

Date	Narrative of 1962 Doctors' Strike in Saskatchewan
May 1962 continued	of a strike. One KOD rally features a caricature of "a supposed Saskatchewan-government imported doctor, with a large Semitic nose, a Chinese pigtail, and middle-east style of clothing, and bearing a large sign reading 'Sask. Gov't Medicare Import'" (p. 55).
May 1962	"Key man" cell organization once again operational. Threats that doctors will vanish from the province foregrounded in news. Announcement made that the largest medical building in Saskatoon would be sold at a loss (p. 54).
May 1962	In contrast to the vociferous activity of the KOD, supporters of the medical care plan were quietly writing letters of support. By the end of May, the Premier's mail was running 8 to 1 in favor of the Act.
June 1962	Meetings occur between citizens in favor of Medicare and a handful of doctors who wanted to maintain normal medical services. Out of these meetings emerge cooperative health associations and community clinics. Doctors agree to work under the terms of the Act and to rent facilities from the lay groups that establish the community clinics.
June 7	Full-page ad under the title "You Are Going to Lose Your Doctors" runs in the <i>Indian Head News</i> . The text reads: "It will be too late when the pain comes in the middle of the night. When the baby suddenly starts choking, when the good farm worker is mangled in the power-takeoff, when the car plunges off the road and scatters dusty bodies in the ditch, when that heart attack comes..." Saskatchewan press receives criticism for selling ads that add "to the frenzy of the people" and for biased reporting (pp. 90-91).
June 22, 1962  June 22, 1962 continued	Doctors official announce their emergency plans: only 29 of the province's 148 hospitals will be staffed. For emergency coverage, they anticipate a need for a minimum of 270 doctors but only have 239 volunteers. On this same day, two private doctors ask the courts to declare the 1960 election null and void and that Saskatchewan Medical Care Insurance Act of 1961 be declared unconstitutional.
June 22-25, 1962	Four meetings between the professions negotiators and the government take place. On June 25, physicians submit their criticism of the Act in writing for the first time. The Premier responds in detail on June 26.
June 30, 1962	Dr. Dalgleish places blame for impeding strike entirely on the government and warns "this very serious situation can only lead to tragedy and the destruction of modern medical care...and the loss of a medical profession" (p. 57). Dalgleish rejects further negotiations on the weekend when strike began saying that "there can be no further negotiations...until this unjust and monopolistic act is withdrawn" (p. 63)
July 1, 1962	At 12:01 am the Saskatchewan Medical Care Insurance Act comes into effect and doctors of Saskatchewan begin their strike. Nine-month-old baby, Carl Derhousoff, dies of meningitis, as parents drive 22 miles over gravel road to Preeceville, then 32 miles to Canora, and then 31 miles to Yorkton in search of medical care (p. 61).
July 3	Canadian Medical Association announces that 60 doctors from Saskatchewan are being assisted in relocating to other places.
July 5	Emergency force of doctors decreases from 240 to 204 doctors.



Date	Narrative of 1962 Doctors' Strike in Saskatchewan
July 6	KOD holds public rally that draws 500 people and live radio coverage in Saskatoon. Catholic priest, Athol Murray warns of "a wave of hatred" sweeping the province. "There has been death, there will be violence and there could be bloodshed," he cried. Tearing off his coat and clerical collar Father Murray shouted, "There are three Reds here. I can't see them. I can smell them." Appealing to patriotism he charged, 'You Communists may think we're naïve and hollow-chested but we gave a hundred thousand boys fighting for the freedom you're fighting against. You Reds, I want you to know that we're as proud as hell to be Canadians.' Attacking the welfare state he stormed, 'Tell those bloody Commies to go to hell when it comes to Canada. I loathe the welfare state and I love the free-swinging freedom. I am seventy and I'll never ask you for the Old Age Pension—to hell with it—I want to be free... We are living in a tragic time—the Ku Klux Klan has come to Canada' (p. 77-78)
July 6	Dr. Ida Fisher, a London-based but Irish-born mother of five, arrives on July 1 as she believes the Canadian doctors are wrong. Striking doctors and KOD supporters undermine her credibility by saying that she has never done an operation and can't do X-rays. Editor of town newspaper writes, "she couldn't thread a needle" or write a prescription. Father Murray calls her a "card-carrying Communist" (p. 84) and she is ejected from the Biggar Hospital. Fisher joined a cooperative clinic that opened in Saskatoon for the remainder of the strike. She demanded that the "scurrilous allegations" made against her be investigated but the College of Physicians and Surgeons did not take any action to investigate her or defend her.
July 9	Fifty women picket meeting of CCF members of legislature holding signs that read: "We Want Freedom for Our Doctors" and "We Don't Want Foreign Scabs" (p. 65)
July 11	KOD organizes march on Regina draws only 4,000 people. Counter-protesters are protected by the police as they were "cursed off the grounds with 'they are Communists. They are going back to the Kremlin.'"
July 14	Front page of the <i>Financial Post</i> runs a strong condemnation of the strike as "an outrageous assault on organized society... The American Medical Association... may be delighted with the Saskatchewan performance. Is anybody else? The striking Saskatchewan doctors in the months and years ahead will not be happy about their guinea-pigging for the AMA" (p. 69)
July 1962	Altogether 110 doctors came to Saskatchewan to provide medical care during the strike, most from Britain, others from other parts of Canada and the United States. The government negotiates stand-by arrangements with other physicians outside of the province, and is prepared to bring them in if the doctors withdraw emergency services.
July 16	Lord Taylor from Britain's House of Lords arrives to help mediate dispute.
July 18	Dr. Dalglish addresses convention of CCF delegates signaling some softening of stances on both sides.
July 23, 1962	Settlement between physicians and government signed thus ending the strike after 23 days.

\*Source: Primary reference material from (Badgely and Wolfe 1967) unless indicated otherwise.

Concluding threads that may be drawn from Exhibits 3.5 and 3.6 will serve as additional ways to provide context for latter discussion of health care reform in the 21<sup>st</sup> century. The success of organized medicine in being able to protect and expand its entrepreneurial activities was contingent on particular social, economic, political, and cultural contexts. The absence of a strong labor movement in the United States combined with the support of business elites for market medicine supported the AMA's opposition to "socialized medicine." The severity of the Depression in Saskatchewan generated and sustained support for the more collective and socialist approaches of the CCF government who were not intimidated by organized medicine. The national policies of sovereign nation-states were highly influenced by formal and informal flows of people and ideas across borders. The tipping point for Saskatchewan's physicians to begin to resist universal health insurance was precipitated by urbanization and an influx of British physicians fleeing the National Health Service. Tactics of opposition to health system reforms in Saskatchewan were heavily influenced by duplicating the public relations campaigns used by the AMA against proposals for universal health insurance. Both Canadian and American opponents to "socialized medicine" used Cold War fears of the Soviet Union to bolster their claims.

It is instructive to note that strategies used by physicians to advocate entrepreneurial medicine in public discourse were multiple. They include strikes, demonstrations, mass media blitzes, "grassroots coalitions" that are underwritten by professional and business elites, lawsuits, lobbying and fiscal support of elected officials through political action committee, standing physicians as candidates for conservative political parties, funding research to support market medicine, boycott of a company funding research adverse to their position, sanctions against "heretical" doctors including denial of hospital privileges, championing support for and sometimes having financial investment in non-profit and commercial health insurance as alternative to single-payer system, refusal to

participate in negotiations with the state and then complain about being excluded, threats of collective non-participation against governmental initiatives, and warnings of mass exodus by doctors from the area or the profession if democratically sanctioned changes to system are implemented.

An historical strategy used by physicians that has particular relevance today was the relentless, expensive, glossy public relations campaigns used in both countries to generate fear at every opportunity. Some of the particular rhetorical gambits are worthy of note. Cartesian dualism and nationalism were mingled together to underpin a conflation of capitalism with democracy. "Free enterprise medicine" was aggrandized in opposition to "corporate medicine," "government medicine," and "socialized medicine"--all were portrayed as the mutually exclusive antithesis to democracy. Intimations of German fascism as well as Soviet communism were used to taint any but market approaches. Explicit appeals to hard versions of religious monotheism were used to bolster associations between "freedom" of market medicine against "tyranny" of government. Catholic women in Canada and "Christian American" doctors were warned about potential conflicts that could threaten their socially conservative views on birth control. Organized medicine used the tropes of oppression such as copious allusions to slavery even as they acted to protect their positions of privilege. Meanwhile, racism abounded in the Keep Our Doctors propaganda directed against foreign "scab" replacement doctors in Canada and directed against those not of the Christian American fold in 1948.

In atmospheres of escalating emotion and primal anxiety, physicians consistently characterized the stance of organized medicine as the best one for patients and the community. Instead of admitting to any self-interest, entrepreneurial medicine was defended as a quality of care issue where "socialized" medicine was presented as not being compatible with "good" medicine. With the strategically termed "compulsory"

health insurance, doctors promised inferior care, higher cost, more bureaucracy, and loss of privacy. They also argued for the “right of the elderly to pay their doctors as much money as they wanted.” More visceral than the claims about potential loss of political freedom, lurid threats that loved ones would die horrible deaths or be maimed were used as emotional blackmail in the doctors’ campaigns against universal health insurance.

If at the end of Chapter Two we were left with the image of Rudolf Virchow wearing his political heart on his biomedical sleeve, we can perhaps close Chapter Three with the 1949 “Keep Politics Out of This Picture!” poster that showed a doctor sitting at a small girl’s bedside as her grief stricken family looks on:

When the life—or health of a loved one is at stake, hope lies in the devoted service of your Doctor. Would you change this picture?  
Compulsory health insurance is political medicine.  
It would bring a third party—a politician—between you and your Doctor.  
It would bind up your family’s health in red tape. It would result in heavy payroll taxes—and inferior medical care for you and your family.  
Don’t let that happen here! (Harris 1966: 45)

This is a biomedical sleeve that is rolled up to get down and dirty in the political muck while pretending that it is only his opponents who are being political. In a pristine white lab coat in one of Flexner’s labs or wiping away fatigue at this desperate deathbed, this is a portrayal of medicine that is never besmirched by politics. Striking a pose of altruism personified, this poster suggests that The Way of the Doctor is hope and life.

CHAPTER FOUR  
DENATURALIZING MARKET FUNDAMENTALISM: IMPACTS OF  
GLOBALIZATION ON HEALTH AND HEALTH CARE SYSTEMS

What are the conditions of possibility that make it seem like the market is the best and only way of organizing our social reality? Does market fundamentalism<sup>135</sup> have implications for health and health care systems? This chapter will explore these questions in four sections. The first section briefly introduces Karl Polanyi's reminder that historically there have been alternatives to getting slapped by the invisible hand of the market. The second section traces the ascent and arguable descent of the welfare state from Franklin Delano Roosevelt to the regimes of Margaret Thatcher, Ronald Reagan, and Brian Mulroney. The third section grapples with a systemic orchestration of a Wild West economic frontier that is then outraged to find cowboys out there doing their jobs by looking at the collapse of Enron. The bulk of this chapter then attempts to outline impacts of globalization on health and health care systems.

Karl Polanyi: Ascent of Economic Determinism

Karl Polanyi<sup>136</sup> makes a persuasive argument that the market economy created a new kind of society. Prior to the nineteenth century economic relations were integral but submerged within social relations. Evidence of this proposition may be found in "primitive" societies where an individual's "place at the campfire, his share in the common resources, was secure to him, whatever part he happened to have played in hunt, pasture, tillage, or gardening" (1968: 65-67). Within this community an individual is not in danger of starvation unless everyone else is sharing the same hardship. Polanyi notes that while markets have long been familiar to many kinds of society, ascribing profit as a universal motive is fairly recent:

The motive of gain was specific to merchants, as was valor to the knight, piety to the priest, and pride to the craftsman. The notion of making the motive of gain universal never entered the heads of our ancestors. At no time prior to the second quarter of the nineteenth century were markets more than a subordinate feature in society (1968: 67)

British Poor Law Reform (1834), the Bank Act (1844), and repeal of the Corn Laws (1846)<sup>137</sup> “established the three tenets of economic liberalism” by creating respectively a labor market, the gold standard, and free trade. Polanyi’s “genealogy of an ‘economic’ society” where “economic motives” are singularly naturalized as the ideologically acceptable explanation for complex human behavior may be contrasted with counter-examples of trade done by various peoples for religious, aesthetic, political, customary, or honorific reasons (1968: 68-69). The vital transition from isolated markets to a “self-regulating system of markets” occurred when labor and land were made into commodities (1968: 61). Previously land and labor were part of the “organic structure of society” and regulated by communal norms; with the commodification of labor and land, human beings and even nature itself became salable.<sup>138</sup> Labor and land were also linked in that the loss of access to common land forced people into waged labor; the enclosure movement in England in the 15<sup>th</sup> to 18<sup>th</sup> centuries “was really the first wave of privatization” (McQuaig 2001: 161).

Polanyi makes two important points that will be helpful in our consideration of globalization and health. The first is that “the market mechanism” or “the market mentality” “created the delusion of economic determinism as a general law for all human society” (1968: 70). The second is to note the transition from the economic system being embedded in social relationships to our current system where social relationships are embedded within and subordinate to the economic system. Both of these threads will be gathered together in later sections of this chapter and in Chapter Five.

Rise and Fall of the Welfare State: The New Deal to “Cowboy Economics”<sup>139</sup>

In his study of regulatory politics in the United States, Marc Eisner (2000: 4-10) delineates four regulatory regimes that arose in response to particular contexts. Consistent with Karl Polanyi’s account, market forces are primordial to Eisner’s account with social relationships subordinated to economic narratives. During the period 1880-1920 as large scale corporations and national markets emerged, the **Market Regime’s** goal was to promote market governance through administrative means such as regulations. The **Associational Regime** arose out of distress associated with the Great Depression. A variety of regulatory systems were instituted to promote industrial stability and “redistribution of national income towards regulated interests” (2000: 8). The **Societal Regime** of the 1960’s and 1970’s arose in response to concerns about environmental and health risks generated by post-war industrialization and growth. The **Efficiency Regime** is associated with growing foreign pressure and economic stagflation in the 1970’s and 1980’s. In contrast to the previous three regimes that increased regulations, the goal of the efficiency regime was to deregulate by eliminating policies that “interfere with market mechanisms or impose large compliance costs” (2000: 8). It is significant that the organizing principle of the various regimes is perpetually in relationship to the market—either how to mitigate adverse effects of the market on individuals, communities, and nature by regulation or how the market can maximize gain by externalizing costs of production onto individuals, communities, and nature by deregulation. Within this context, this section will focus on the Associational Regime (often called the Welfare State) as an example of the former and the Efficiency Regime (or Reaganomics) as an example of the latter.

In the context of a country that “was dying by inches” as Franklin Delano Roosevelt (1933b) described the effects of the Great Depression, Roosevelt accepted the nomination for President with a pledge for “a New Deal for the American People.”<sup>140</sup> In

his first inaugural address<sup>141</sup> that includes “the only thing we have to fear is fear itself” aphorism, Roosevelt castigated the “practices of the unscrupulous money changers” and exhorted social values other than pecuniary profit:

The measure of the restoration lies in the extent to which we apply social values more noble than mere monetary profit. Happiness lies not in the mere possession of money; it lies in the joy of achievement, in the thrill of creative effort. The joy and moral stimulation of work no longer must be forgotten in the mad chase of evanescent profits. These dark days will be worth all they cost us if they teach us that our true destiny is not to be ministered unto but to minister to ourselves and to our fellow men (Roosevelt 1933a)

New Deal promises of hope and policies of action built the Welfare State that was made needful by the “mad chase of evanescent profits.”<sup>142</sup> A basic premise in the rhetoric of the Welfare State is that those who are strong have a responsibility to care for those who are vulnerable. In his second inaugural address,<sup>143</sup> Roosevelt proclaimed:

But here is the challenge to our democracy: In this nation I see tens of millions of its citizens—a substantial part of its whole population—who at this very moment are denied the greater part of what the very lowest standards of today call the necessities of life.

I see millions of families trying to live on incomes so meager that the pall of family disaster hangs over them day by day....

I see one-third of a nation ill-housed, ill-clad, ill-nourished.

It is not in despair that I paint you that picture. I paint it for you in hope—because the Nation, seeing and understanding the injustice in it, proposes to paint it out. We are determined to make every American citizen the subject of his country's interest and concern; and we will never regard any faithful law-abiding group within our borders as superfluous. The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little (1937).

A Welfare State perceives suffering and is willing to make response to that suffering a measure of its legitimacy as a regime.<sup>144</sup> Critics of the New Deal such as Justice Janice Brown interpret the New Deal as “the triumph of our socialist revolution” (Editorial: Out of the Mainstream, Again 2003). Roosevelt’s New Deal set the stage for Lyndon B. Johnson’s “Great Society:”<sup>145</sup>

Your imagination, your initiative, and your indignation will determine whether we build a society where progress is the servant of our needs, or



a society where old values and new visions are buried under unbridled growth. For in your time we have the opportunity to move not only toward the rich society and the powerful society, but upward to the Great Society.

The Great Society rests on abundance and liberty for all. It demands an end to poverty and racial injustice, to which we are totally committed in our time.....It is a place where men are more concerned with the quality of their goals than the quantity of their goods (1964).

Roosevelt and Johnson have been quoted at length in order to underscore the radically egalitarian agenda common in their rhetoric as well as their willingness to privilege other than material values. Their assumption of possibilities inherent in collective action by and through governments may be contrasted with Ronald Reagan's first inaugural address:<sup>146</sup>

The business of our nation goes forward. These United States are confronted with an economic affliction of great proportions. We suffer from the longest and one of the worst sustained inflations in our national history. It distorts our economic decisions, penalizes thrift, and crushes the struggling young and the fixed-income elderly alike. It threatens to shatter the lives of millions of our people.

Idle industries have cast workers into unemployment, causing human misery and personal indignity. Those who do work are denied a fair return for their labor by a tax system which penalizes successful achievement and keeps us from maintaining full productivity.

But great as our tax burden is, it has not kept pace with public spending. For decades, we have piled deficit upon deficit, mortgaging our future and our children's future for the temporary convenience of the present.....

In this present crisis, government is not the solution to our problem ... We are a nation that has a government—not the other way around. And this makes us special among the nations of the Earth. Our Government has no power except that granted it by the people. It is time to check and reverse the growth of government which shows signs of having grown beyond the consent of the governed. Now, so there will be no misunderstanding, it is not my intention to do away with government. It is, rather, to make it work—work with us, not over us; to stand by our side, not ride on our back. Government can and must provide opportunity, not smother it; foster productivity, not stifle it (1981).

In contrast to his predecessors who saw institutions that they lead as agents of change to ameliorate social problems, Reagan defined government as the problem<sup>147</sup> riding “on our back.” Although Reagan weaves “struggling young” and “fixed-income

elderly” into his speech as token victims to be crushed by inflation, he simultaneously characterizes entitlements that might soften their plight as frivolous “temporary conveniences of the present” that mortgage “our future and our children’s future.” Reagan’s Gestalt is captured by one of his first lines in his role as President: “the business of our nation goes forward.” The neoliberal values that Reagan embraces are exactly those denigrated by Roosevelt as a “mad chase of evanescent profits.”

As “apostles of the new right” (Savoie 1994: 8), the regimes of Ronald Reagan, Margaret Thatcher, and Brian Mulroney set out to dismantle the Welfare State. The “Thatcher Revolution” that began with her 1979 election victory was characterized by “ideologically driven programs of privatization, deregulation, contracting out, and trade union reforms” (Savoie 1994: 9). A basic premise for Thatcherites was “the government cannot be expected ‘to do something’ about the conditions of individuals and families in a modern liberal state”(Letwin 1992: 39). This is consistent with Thatcher’s perspective that “there is no such thing as society. There are individual men and women, and there are families.”<sup>148</sup> A key objective of the Thatcher administration was to “Deprivilege the Civil Service” by reducing their numbers, “concentrating on essential functions,” and improving efficiency (Savoie 1994: 92).

Reagan’s metaphors for the federal bureaucracy included “overgrown and overweight” and a promise that he had come to Washington “to drain the swamp” (Savoie 1994: 92). Reagan and his advisors “detested” government and “felt that they had a mandate to ‘smash government programs that had created the welfare state’” (Savoie 1994: 9). Garry Wills explains Reaganomics as follows:

Since government was the problem, not the solution, just getting government out of the way would be a solution to every economic ill. The Gulliver of American capitalism, tied down with a thousand strings by Lilliputian bureaucrats, would spring up into boisterous activity...Supply side was cowboy economics—you get your free lunch by roping and throwing meat on the hoof, lassoing it with the Laffer curve. Any cowboy

can do that on his own, so long as he is not obstructed by timid city folks in green eyeshades (1987: 433).

Prototypical cowboys<sup>149</sup> don't need much in the way of society and survival lore favors those who do not exhibit too much tenderness towards that which is lassoed.

By 1985 the mantra of "free markets, fiscal restraint, and monetary prudence" reaffirmed at the Bonn G-7 Summit was being described by *The Economist* as "the Ronald Thatcher message" (Corcoran 1988). Brian Mulroney was "arguably not as ideological in thinking" as Thatcher and Reagan (Savoie 1994: 10), but Mulroney replicated their policies in the "Blueing of Canada" (Goar 1987). On the campaign trail, Mulroney promised that once in office he would hand out "pink slips and running shoes to bureaucrats" (Savoie 1994: 4). The Mulroney government's first statement on the economy, tabled a few weeks after coming into office, posited the now familiar refrain: "Government has become too big. It intrudes too much into the marketplace and inhibits or distorts the entrepreneurial process" (Government of Canada 1984: 23).

#### Normalizing Iran-Contra and Endemic "Enronitis"<sup>150</sup>

A characteristic common to Thatcher, Reagan, and Mulroney is that their ideas, if not their actual political careers in Mulroney's case, prevailed over what has politely been termed "credibility problems" (Westell 1986). Thatcher, "She-Who-Must-Be-Obeyed" (Savoie 1994: 144), brazened her way through scandals by being "economical with the truth" (Westell 1986). To take but one example, a week after denouncing civil servants as disloyal for leaking classified documents, Thatcher's government ordered civil servants to leak classified documents in the Westland helicopter controversy. Thatcher's Secretary of the Cabinet, Sir Anthony Armstrong, confirmed Thatcher's version of events by explaining "a disclosure which has been authorized isn't a leak" but an "authorized disclosure in the public interest" (Bruce 1986).

While describing Thatcher as “devious,” Anthony Westell (1986) characterizes Ronald Reagan’s predicament with the Iran-Contra Scandal as either being “guilty of conspiracy” to deceive Congress or “guilty of incompetence” in running his administration. Westell speculates that “he may come off looking like a nice old guy who now has only 60-watt bulbs upstairs, can’t really be blamed for what goes wrong and has only a couple of years left in office anyway.” Moving beyond a theory of low wattage, Garry Wills’ biography of Reagan is a portrayal of one “trained to rectitude, not to questioning” (1987: 63). Holding fast to his values, Reagan “did not seem to be affected by the reality of what he was doing” (Wills 1987: 378). He insisted that he cut government spending when he raised it dramatically, he called himself “a rabid union man” (Wills 1987: 254) yet dissolved the Professional Air Traffic Controllers Organization after firing the striking controllers (Tesh 1988: 108-109), and never believed the effects of his policies (Wills 1987: 437).<sup>151</sup> Ronald Reagan “could will his own innocence” (Wills 1987: 191). People were willing to dismiss criticisms of his fantasies: using a metaphor that Reagan would have appreciated, one woman told Wills that “even Jesus spoke in parables”(1987: 467).

While “She-Who-Must-Be-Obeyed” and the “Great Communicator” could be endearing or at least respectful monikers, it is a bit more challenging to put a positive spin on the not-infrequently-heard “Lying Brian.” Westell (1986) posits that Brian Mulroney’s lack of credibility arises not from any one incident but from “the widely held suspicion that he is both devious and incompetent.” These suspicions have been substantiated by investigative political journalist, Stevie Cameron in *On the Take: Crime, Corruption and Greed in the Mulroney Years* (1995). Mulroney did not even have a facade of innocence to hide behind. His 1984 chuckling comment “there’s no whore like an old whore” when he heard outgoing Prime Minister Pierre Trudeau was rewarding former cabinet minister, Bryce Mackasey with a choice patronage appointment was seen as

“cynicism reflecting his true political philosophy”(Cameron 1995: 457). This impression was later validated by Mulroney’s own flurry of patronage appointments, sweetheart deals, and blatant corruption that followed campaign promises to “clean up a corrupt system” (Cameron 1995: 183).

The point here is not to fault individual politicians for mistakes but to suggest that what some people would consider to be behavioral excesses were consistent with the norms and aspirations of their ideological matrix. Common folk who lie, steal, or appear incompetent might face some legal and social challenges. Not only were Thatcher, Reagan, and Mulroney not impeached, recalled, or indicted, but their personalities and platforms continue to be valorized twenty years later in much of mainstream culture in the United States and Canada. George W. Bush is considered by some commentators to be Ronald Reagan’s ideological “son” more than George H. Bush’s progeny, exemplified by even rehiring several of those responsible for the Iran-Contra scandal (Keller 2003). Within the logic of the market, instrumental gambits are not necessarily perceived as errors or flaws. Bill Keller (2003) suggests:

What Bush is striving for, on the evidence of the choices he has made so far, is bold in its ambition: markets unleashed, resources exploited. A progressive tax system leveled, a country unashamed of wealth. Government entitlements gradually replaced by thrift, self-reliance and private good will. The safety net strung closer to the ground. Government itself infused with, in some cases supplanted by, the efficiency and accountability of a well-run corporation. A court system dedicated to protecting property and private enterprise and enforcing individual responsibility. A global common market that hums to the tune of American productivity. In the world, American rampant—unfettered by international law, unflinching when challenged, unmatched in its might, more interested in being respected than in being loved.

This is a clear privileging of the market and American imperialism over any notions of solidarity with social relationships that might be made manifest by respect of international law, global public goods, or social justice. Karl Polanyi could not ask for a clearer illustration of an ideology of an aggrandized market mentality that severs

economic mechanisms from social relationships than Bush's unleashed markets, exploited resources, and low-slung safety nets.

Given the naturalization of gain as a universal value should we then be shocked or even surprised by a seemingly never-ending cascade of scandals? Enron, for example, at its height of power had a reported annual revenue of \$100 billion and a workforce of 26,000 people, has become "a symbol of corporate excess and fraud" (Executives on Trial: Scandal Scorecard 2003). When the energy company went bankrupt in 2001, thousands lost not only their jobs but also their life savings invested in pension funds only to discover that Enron's team of 144 senior managers received \$744 million.<sup>152</sup> By relentless lobbying<sup>153</sup> for energy deregulation in California and then "gaming" the system by "megawatt laundering,"<sup>154</sup> Enron and other corporations made huge profits<sup>155</sup> from the California energy crisis<sup>156</sup> (McLean and Elkind 2003: 264-283). Enron's independent auditor, Arthur Andersen, filed for bankruptcy after it was convicted of obstructing justice<sup>157</sup> by shredding evidence related to Enron's financial shell game thereby reducing the world's big five accounting firms to four (Transparency International 2003:80). Described as "a steady accumulation of habits and values and actions" that went on for years (McLean and Elkind 2003: 132), the Enron debacle would not have been possible without the complicity of investment banks, investment analysts, lawyers, regulators, consultants, journalists, politicians, and credit-rating agencies such as Moody's and Standard & Poor's invested in a culture of market meritocracy.<sup>158</sup>

Enron is not an anomaly. Adelphia Communications,<sup>159</sup> Global Crossing, Halliburton, WorldCom and Xerox also experienced difficulty with "misleading accounting" (Transparency International 2003: 84). Financial institutions such as Citigroup's Salomon Smith Barney have paid multiple millions to settle fraud charges related to "overly rosy" stock recommendations and suspect dealings with Enron and Dynegy.<sup>160</sup> The founder and chief executive officer of ImClone, Sam Wacoal, was

sentenced to seven years in prison for insider-trading,<sup>161</sup> bank fraud, obstruction of justice, perjury, and tax evasion (Associated Press 2003b). Charges have been filed against 47 people for rigged currency trading described as a “pattern of deep-rooted and apparently long-running fraud within the currency exchange industry” at some of “Wall Street’s biggest banks” (Fuerbringer and Rashbaum 2003). At the time of this writing there is also a “growing mutual fund scandal” that former Securities and Exchange Commission chairperson, Arthur Levitt describes as “the worst scandal we’ve seen in 50 years” without excluding Enron and WorldCom (Krugman 2003).<sup>162</sup>

Although this is once again a topic where illustrations could be infinitely multiplied these examples should be sufficient to suggest a pattern. This is not to suggest that ethical slippery slopes are confined to corporate terrains: the behavior of politicians,<sup>163</sup> civil servants,<sup>164</sup> athletes,<sup>165</sup> and high school students<sup>166</sup> have all been under scrutiny during the last year for pushing the edges of the market mentality. Rationales that have been offered to interpret these patterns of behavior are as fascinating as the machinations themselves. One approach is to send conflicting messages, as did chief executive officer of Pfizer, Henry McKinnell, in his capacity as vice chair of the Business Roundtable’s corporate governance task force. McKinnell states both that “I’ve never seen anything of this magnitude with companies this large” and “things aren’t as broken as they appear to be” (Wessel 2002). Some individualize with the “one bad apple” theory of regrettable, aberrant behavior that arises from human nature and personal agency characterized by cupidity or stupidity. The introductory question posed by the *Wall Street Journal* in an article subtitled “How Could They Have Done It?” asks: “Did a bacillus descend from space and make Enron senior employees in equal parts evil and stupid?” (Jenkins 2002). Besides noting the ubiquitous metaphor of contagion generated in this instance from a culpability space not even from this planet, it is instructive to note what Jenkins is definitely more outraged by:

Maybe it's too much to ask them to be invariably honest but we could expect them not to be self-defeatingly stupid. In most cases thieves either plan to get away with or think they aren't stealing. Enron executives seem to have believed they weren't stealing (Jenkins 2002).

What Jenkins characterizes as stupidity calls to mind Gary Wills's description of Ronald Reagan's willful innocence that enabled him to be unaffected by the reality of what he was doing.

A more structural approach might ask what are the conditions that make these recurring patterns of willful innocence possible? Harvey Cox, Professor of Divinity at Harvard University, discovered that his vast experience at decoding metanarratives was pertinent when reading the *Wall Street Journal*:

Behind descriptions of market reforms, monetary policy, and the convolutions of the Dow, I gradually made out the pieces of a grand narrative about the inner meaning of human history, why things had gone wrong, and how to put them right. Theologians call these myths of origins, legends of the fall, and doctrines of sin and redemption. But here they were again, and in only thin disguise: chronicles about the creation of wealth, the seductive temptations of statism, captivity to faceless economic cycles, and ultimately, salvation through the advent of free markets, with a dose of ascetic belt tightening along the way, especially for the East Asian economies (Cox 1999).

Cox makes an argument for The Market as an omnipotent, omniscient, and omnipresent God that is a source of mystery and reverence for the faithful. Robert Bartley, an apologist<sup>167</sup> for "human nature" as evinced in the various accounting scandals uses the tropes of religion as he warns against "rushing to judgment" and the difficulty of knowing "where the actual sins lie" (2002). Mixing the tropes of religion and medicine Bartley disparages the possibilities of "a silver bullet for human nature:"

The truth is that analysts, CEOs, directors and investors too were caught up in one of those periodic moments of human euphoria. Better corporate governance will help at the margin, but if you're going to find a cure, it will have to cure human nature (Bartley 2002)

Another *Wall Street Journal* reporter, David Wessel, in an article titled "What's Wrong? Venal Sins: Why the Bad Guys of the Boardroom Emerged en Masse" suggests



that the bubble economy that was the context for Enron was similar to what Federal Reserve chairperson Alan Greenspan called the “irrational exuberance” of the 1990s and what economist John Kenneth Galbraith<sup>168</sup> saw as cyclic “inventory of undiscovered embezzlement” that remains hidden until times of depression such as the crash of 1929 when “commercial morality is enormously improved.” Mutual fund manager James Gipson explains:

There is a tendency during boom times for even honest people to shift their moral compasses, and there is a belief that everyone else is doing it. It's when the music stops, if you will and the scrutiny goes up that the over-the-top cases become apparent (Wessel 2002)

With a perception that “everyone was doing it” there was a “decay of professionalism” and people got into “an ethical vacuum space.” This vacuum included people with oversight and accountability functions as John Coffee<sup>169</sup> explains: “The professional gatekeepers were greatly compromised by finding they could make tremendous profits by deferring to management” (Wessel 2002).

Even if Alan Greenspan is correct in his view that human greediness did not increase in the 1990s, but merely the opportunities increased with risking stock prices (Wessel 2002), questions remain. What was driving the creation of those opportunity mechanisms? Why are markets framed as if there is no human agency behind them? What caused people to recalibrate their moral compasses? If we reject extraterrestrial microorganisms causing rampaging evil and stupidity we could ask: why was “everyone doing it” or why did it seem plausible to believe this behavior to be customary?

If divine omnipotence is “the capacity to define what is real” (Cox 1999), The Market as God naturalizes the primacy of economic relationships over any other ways of organizing society. This is a fundamentalism that is willfully ignorant of the suffering and death it causes to the bodies and spirits of human beings, nature and

other species, and communal relationships. This is the fundamentalism that naturalizes the most technical capability to ameliorate sickness and also naturalizes inequities that cause disease and prevent access to medical care. This is the fundamentalism that makes it seem normal that some but not all around the campfire should die from want. And this is the fundamentalism that has increased its faith in the inability to organize the world in any other way from Karl Polanyi's "economic determinism" to Linda McQuaig's (1998) description of acquiescence to globalization as "the cult of impotence."

### Impacts of Globalization on Health and Health Care Systems

Modern globalization has been characterized as an accelerated movement of information, goods, capital, and people across geographical and political borders (Daulaire 1999: 22). Nils Daulaire argues that while the movement of people and goods is certainly not a unique historical phenomenon, the pace and tempo of change is new and made possible by advances in communication and transportation technologies. Manuel Castells (1996) signals the centrality of computers and the Internet by describing the product of the "information technology revolution" as "the network society."

From the vast globalization literature we can draw out some organizing principles that will help elucidate some of the basic dynamics of the ultimate "market mentality" or "capitalism on steroids" characteristics of globalization. Neoliberalism,<sup>170</sup> as evinced by Thatcherism and Reaganomics, is the underlying ideology of globalization (Shakow and Irwin 2000) (Steger 2000). Neoliberalism asserts that market forces left unfettered lead to optimal societal outcomes. Its economic and moral presupposition is that economic and social aspects of life, including wealth and poverty, can be understood in terms of individual "choices" (Shakow and Irwin 2000: 52-54).

"Neoliberal theories yield a triple prescription: liberalization, privatization, and

deregulation" (Shakow and Irwin 2000: 54). A side-effect of this prescription is a devolving role for the state or "the shrinking state" (Neubauer 1997). Multinational and then transnational corporations are "globalization's primary engine" (Neubauer 2000: 16) (Barnet and Muller 1974; Barnet and Cavanagh 1994). At one end of the globalization debate spectrum, critics argue that neoliberal regimes privilege profit for corporations over needs of civil society at an unsustainable pace that portends ecological and humanitarian doom. At the other end of the spectrum apologists for globalization typically deny or minimize globalization's adverse effects or co-opt concern for the disenfranchised by suggesting that poverty is exacerbated by naïve critics who would slow economic progress.<sup>171</sup> Globalization as a form of Americanization is another gloss that tends to be polarized. McDonaldization is a paradigm to describe the "process by which the principles of the fast food industry are coming to dominate more and more sectors of American society as well as the rest of the world" (Ritzer 2000: 1). Ritzer suggests that the success of McDonald's is due to the principles of efficiency, calculability, predictability, and control (2000: 12). Those who resist the franchising of these principles across geographical and social domains<sup>172</sup> are concerned about cultural homogenization as identities are threatened by erasure of traditions and regional variations (Castells 1997).

"The contested narratives of globalization" is a helpful trope that Deane Neubauer often uses to unpack conflicting, converging, and contradictory tales of the constitutive elements, processes, dynamics, impacts, and implications of globalization. There is a Wild West account of globalization framed as a frontier story. At the height of the New Economy boom, globalization was described by an Internet company executive as a "land grab. You stake as many claims as you can think of, and then work to nail them down" (Neubauer 2000: 13). While the wranglers are now of data and the outlaws are of software, governments that privileged railroads and settlers against indigenous

peoples and imported labor continue to subsidize “predatory capital.”<sup>173</sup> The glow from panned gold or from wily investments has long promised opportunity to the bold as it casts shadows on the marginalized. With eyes fixed on the cowboy, the price of the frontier paid by the Indians decimated along the Trails of Tears<sup>174</sup> or still awaiting redress for the Bhopal<sup>175</sup> gas disaster often goes unacknowledged. When suffering caused by globalization is recognized it is often cast as a regrettable but unavoidable cost of progress<sup>176</sup> much as Andrew Carnegie was willing to accept inequalities to insure “the survival of the fittest” in his “Gospel of Wealth.”<sup>177</sup> The logic of the Wild West Economy is that the top 20% of the population in each country will actively participate in production and consumption while the other 80% will be unemployed nonconsumers. As John Cage, top manager at Sun Microsystems, phrased it: “the question in the future will be to have lunch or be lunch” (Martin and Schumann 1997: 4).

To have lunch or be lunch is a normative precept that gives insight into the ethos of the frontier. Fence lines between ordinary cowboy economics and Enron economics may be hard to discern when the herd all seems to be traveling in the same direction. What are the implications for the social order of bifurcating people into gourmands and comestibles? What are the implications of inequality for health and health care systems?

Some of the potential impacts of these organizing principles on health and health care systems are outlined in Exhibit 4.1. This is followed by selected illustrations of the North American Free Trade Agreement’s Impact on determinants of health and state sovereignty in Exhibit 4.2.



Dynamic	Potential Impact on Health	Potential Impact on Health Care Systems
<i>Growth of "Information Society" or "Knowledge Economy"</i>	Rapid advances in science and technology have profound implications for prevention and treatment of disease for those who can afford access. Internet and other mass media allow for rapid diffusion of new possibilities for treatment thereby generating demand and iatrogenic possibilities. Increased connectivity raises possibilities for increased global solidarity and mobilization of social movements that could impact determinants of health while underscoring the "digital divide." <sup>190</sup>	Increasing complexity of technology expands need for specialization of health care workers and facilities while escalating costs. Raised public awareness may generate disappointment based on unrealistic expectations. Increasingly knowledgeable "health care consumers" may challenge traditional authority of physicians. Telemedicine and telehealth expand the scope for consultation and treatment of patients geographically distance and for continuing education of health care workers. <sup>191</sup>
<i>Trade liberalization: Increasing fluidity of "casino economy" and capital aggregation</i>	Volatility of flows may precipitate crisis such as "Asian Flu" of 1997 causing hunger, massive unemployment, and social disruption. George Soros and others make fortunes betting against currencies. Corporate fraud causes unemployment and loss of pensions for employees while executives thrive. Poverty increases vulnerability to illness and death. Income and wealth inequalities widen within and between societies (accompanied by morbidity and mortality disparities distributed by class.) <sup>192</sup>	Economic instability leads to contraction of health care services at the same time as health needs increase due to declining standards of living. <sup>193</sup> Corporations within the health care industry also generate profit through fraud and criminal conspiracy. <sup>194</sup>
<i>Trade liberalization: Capital chases cheapest labor and most generous tax incentives across national borders</i>	Unionized, higher paying jobs in manufacturing sector disappear as non-union, low pay service work increases in North America. <sup>195</sup> Unemployment, underemployment, and lack of work control associated with increased morbidity and mortality. Overwork, underpay, and marginal working conditions task health of workers with jobs. <sup>196</sup>	Expenditures on luring transnational companies siphon off money available for social expenditures, including health services. Unions decline in strength in health sector as work is outsourced and sophisticated propaganda argues for "need to be competitive." <sup>197</sup>

Dynamic	Potential Impact on Health	Potential Impact on Health Care Systems
<i>Trade liberalization: "free trade" regime privileges rights of corporations over needs of civil society including vigorous protection of "intellectual property rights."</i>	Chapter 11 of NAFTA allows corporations to sue nation states over health and safety regulations that might decrease profits (e.g. gasoline additives.) As markets in industrialized countries decrease for addictive substances such as alcohol and tobacco decrease, corporations turn to developing and newly emerging economies for new markets. Other products, that are not substantially harmful such as milk formula, become lethal when vigorously promoted to families in developing nations. Without adequate access to clean water or resources to purchase sufficient quantities of the product once breast milk has dried up, children die from dehydration.	"Biopiracy" <sup>198</sup> of indigenous people and their cultural practices by corporations may result in people having to pay for commodified versions of their traditional healing practices or therapies derived from their own genetic material. Ultimate implications of NAFTA, GATT, and WTO for ability of nation states to control their own health care systems uncertain. <sup>199</sup> Aggressive propulsion of "intellectual property rights" mitigates against development of generic pharmaceuticals and other technologies at affordable cost.
<i>Trade liberalization: promotes unchecked industrialization, urbanization, and unsustainable consumption patterns</i>	Environmental degradation in the form of air, water, and land pollution introduces toxins and provokes violence over increasingly scarce resources such as fresh water and food. Increases of ultraviolet radiation from ozone depletion cause skin cancers, cataracts, and immunosuppression. Global warming shifts patterns of vectors of infectious diseases, causes death from heat waves, trauma from floods and storms, and famine from drought. <sup>200</sup> Poor people are typically disproportionately affected by all of the above.	Health care systems are complicit with normalizing "natural disasters" as apolitical events. Lack of surveillance of differential impact on poor people and unwillingness to track root causes of environmental degradation naturalizes and depoliticizes disasters. <sup>201</sup>
<i>Devolving State: Deregulation</i>	Dismantling and declining enforcement of regulations exacerbates environmental degradation; threatens food, water, product, and services safety; and encourages labor exploitation. <sup>202</sup>	Canadian Health Coalition campaigns against deregulation or regulatory changes designed to "re-regulate" in economic favor of biotechnology and pharmaceutical industries. <sup>203</sup>

Dynamic	Potential Impact on Health	Potential Impact on Health Care Systems
<i>Devolving State: Privatization</i>	Structural adjustment programs that privatize water, energy, and other essential services increase costs to individuals and vulnerability of poor to disease and death.	Structural adjustment programs that privatize health services and impose user fees decrease access globally for poor and working classes especially. Market solutions are aggressively promoted for public health systems in industrialized countries that experience "crisis" in access or quality of care caused by underfunding or "death of a thousand cuts."
<i>Devolving State: Retreat from Universalism and Welfare State</i>	Web of the "social safety net" frays as people do not receive essential services. <sup>204</sup> Shorter hospital stays and increased reliance on homecare has shifted responsibility from institutions to individuals and families with women caregivers disproportionately under stress from multiple demands. <sup>205</sup>	Delisting of medical services from public health plans and increasing deductibles for prescription drugs shifts cost burden from public to unwell individuals. Armstrong et al argue that privatization and health care reform is having a negative impact on many women in Canada as health care workers and as caregivers. <sup>206</sup>



**Exhibit 4.2 Selected Illustrations of North American Free Trade Agreement's Impact on Determinants of Health and State Sovereignty**

Illustration	United States	Mexico	Canada
Employment and Unemployment	An estimated 766,030 jobs are lost between 1994 and 2000 due to NAFTA. <sup>207</sup>	Official unemployment rates are lower after NAFTA. Number of employed has increased by about 1.3 million per year. <sup>208</sup> Maquiladora employment grew from 60,000 in 1975 to 420,000 in 1990 to 1.3 million in 2000. <sup>209</sup>	Between 1989 and 1997, Canada had a net destruction of 276,000 jobs. <sup>210</sup> Unemployment rates in the 1990s averaged 9.6% compared to the USA rate of 5.8%. <sup>211</sup> Eligibility regulations change so that 75% of unemployed collected unemployment benefits in 1990 compared to 36% in 2000. <sup>212</sup>
Wages and Income	With loss of manufacturing jobs, workers have moved to lower paying service sector. Earnings of displaced workers declined by an average of 13%. <sup>213</sup>	Income for salaried decreased by 26.6%, piece or percentage workers decreased by 47%, and self-employed by 49.6% from 1991 to 1998. <sup>214</sup> Minimum wage has lost 50% of its purchasing power since 1990. <sup>215</sup>	Market incomes of bottom 10% of families with children fell 84% during 1990-1996, and those of next 10% fell 31%. <sup>216</sup>
Collective Bargaining and Unions	Employers threaten to close all or part of their operations during union organizing drives. <sup>217</sup>	Labor income in industries whose bargaining processes are under federal supervision lost more than 21% of their purchasing power between 1993 and 1999. <sup>219</sup>	Plant closures, layoffs, and "years of defensive bargaining" have eroded strength of unions. Overall unionization rate slipped from 32% of paid workforce in 1987 to 30.7% in 1998. <sup>221</sup>
NAFTA labor side agreement	From 1994 to 2001 there were 7 cases filed against the U.S. <sup>218</sup>	From 1994 to 2001 there were 14 cases filed against Mexico. <sup>220</sup>	From 1994 to 2001 there were 2 cases filed against Canada. <sup>222</sup>

Illustration	United States	Mexico	Canada
Wage/ Income Inequality	Trade is responsible for 15-25% of the growth of wage inequality <sup>223</sup>		"War on the deficit" provided rationale for cuts for safety net payments thereby increasing overall income inequality for the first time since WWII. <sup>224</sup>
NAFTA's Chapter 11 gives "specific protections of investor rights." <sup>225</sup> It is "designed to protect the right of corporate investors to earn profits, and to be compensated fully for unrealized profits whenever government action or legislation—even when it is designed to protect its own citizens—interferes with this "right." <sup>226</sup>	Canadian chemical company, Methanex Corporation, challenges California's phase-out of MTBE. This gasoline additive has contaminated surface and ground water throughout California with a turpentine taste and carcinogenic potential. Methanex is suing for \$970 million in damages. Tribunal has accepted admissibility of the case but has requested evidence to support allegation that Gov. Grey Davis was improperly influenced by competitor. <sup>227</sup>	U.S. based waste management company, Metalclad Corp. challenges decision by Mexican local government to refuse it a permit to operate a hazardous waste landfill and by state government to create an ecological preserve on that site. Company seeks \$90 million U.S. in damages. Tribunal rules against Mexico and orders it to pay \$16.4 million. Mexico appealed, court allowed most of tribunal award to stand, and Mexico paid undisclosed sum to investor. <sup>228</sup>	U.S. based Ethyl Corporation challenges Canadian ban on import and inter-provincial trade in gasoline additive MMT. In addition to being a suspected neurotoxin, carmakers claim that MMT infers with on-board diagnostic systems. Ethyl's claim for \$250 million US is settled "out-of-court" for \$13 million, an apology to the company, and a repeal of the ban on MMT. <sup>229</sup>
Additional examples of Chapter 11 challenges	Canadian funeral home, Loewen Group Inc. challenges a civil case ruling against it by a jury in Mississippi state court. Amount claimed for damages is \$725 million. Tribunal is pending. <sup>230</sup>	U.S. GAMI Investments, Inc. challenges Mexican regulations regarding processing and export of sugar as well as nationalization of failing sugar refineries. Claim is for \$55 million US. Results are pending. <sup>231</sup>	U.S. water firm, Sun Belt Water Inc. challenges British Columbia water protection legislation and moratorium on exports of bulk water from the province. Claim is for \$10.5 billion U.S. Canadian government states that the claim is inactive while investor asserts that claim is pending. <sup>232</sup>

Returning to a typology of discursive approaches to health outlined in Exhibit 2.2, let us make explicit some of the elements commonly used in the “population health” or “social determinants of health” literature typical of social production of disease and health approaches. Exhibit 4.3 delineates key focus areas respectively by Health Canada<sup>233</sup> and the Social Determinants of Health Campaign<sup>234</sup> sponsored by the World Health Organization’s Healthy Cities Europe project:

**Exhibit 4.3 Determinants of Health for Health Canada and Healthy Cities Europe**

	Health Canada <sup>a</sup>	Healthy Cities Europe <sup>b</sup>
1.	Income and Social Status	Social Gradient
2.	Social Support Networks	Stress
3.	Education and Literacy	Early life
4.	Employment and Working Conditions	Social Exclusion
5.	Social Environment	Work
6.	Physical Environment	Unemployment
7.	Personal Health Practices and Coping Skills	Social support
8.	Healthy Child Development	Addiction
9.	Biology and Genetic Endowment	Food
10.	Health Services	Transportation
11.	Gender	
12.	Culture	

- a. Source: Population Health section of the Health Canada website  
<http://www.hc-sc.gc.ca/hppb/phdd/determinants/determinants.html#income>  
 b. Source: (Wilkinson and Marmot 2003)

While particular areas of focus may be framed differently by these mainstream organizations in Canada and Europe, what is common to both is that they are striving to expand the discourse on health beyond biomedicine and medical services. The argument here is that while biological sciences and systems of health care are obviously important for those who have access to them, all too often a fetishization of these elements precludes serious study and engagement with alternatives that are more comprehensive in scope and regime challenging in their implications.

When considering the nexus between globalization and health, it is important to acknowledge that neoliberal fundamentalism that privileges economic over social relationships resists building social contexts that are equitable, socially cohesive and

supportive, and nurturing of life. Although a quest for profits may coincide with the common weal or public interest, it may not. A pertinent historical example is the purposeful dismantling of mass transit infrastructure in the United States by General Motors. In the 1920s when nine out of ten people used trolleys, General Motors started to purchase and then destroy the nation's trolley companies. Trolleys were replaced with General Motor's diesel-fueled buses and soon National Car Lines (funded and controlled by General Motors) was operating public transit in 80 cities. A propaganda campaign featuring the slogan "What's Good for General Motors is Good for America" was mounted by the automobile industry to depict cars as modern, time-saving alternatives to slow, inefficient public transportation systems. The president of General Motors, Charles Wilson, was appointed Secretary of Defense in 1953 and supported public funds to underwrite a national highway system as a "national security issue" (Fuller 1998: 9). In the 1960s, Firestone, Standard Oil, NCL, and General Motors were convicted in an anti-trust suit of "conspiring to destroy public transportation in the United States" and General Motors paid a fine of \$5,000 (Fuller 1998: 9-10). Colleen Fuller makes a persuasive argument that the norms for corporations in the health care industry are the same as for other for-profit corporations:

A "good" corporation is simply one that earns a high rate of return, just as a "good" table is one that stands firmly on its four legs. Similarly, a company that registers low profit margins because it upholds the values of the community is "bad," just as a table that can't stay up is worthless. Health corporation executives who care more for patients than for profits are neglecting their mandate; they are shirking their responsibility to investors, and such conduct is subject to the scrutiny and discipline of the market (1998: 10).

It should not be surprising then that health care corporations faithful to the discipline and mores of the market have amassed \$4.21 billion in fines, settlements, and restitution payments in the last three fiscal years compared with \$3.29 billion in the prior ten years combined (Callahan 2003). Just from January to August 2003 the federal

government in the United States was set to collect more than \$2 billion in payments from Abbott Laboratories, AstraZeneca PLC, Bayer AG, Guidant Corp., GlaxoSmithKline PLC, HCA Inc., Pfizer, and Tenet Healthcare Corp. (Callahan 2003). Arthur Caplan, chair of the Department of Medical Ethics at the University of Pennsylvania Medical School is quoted:

...ethics in the health-care industry have slipped in recent years and companies began to bend the rules of government insurance programs to meet investors' expectations. "There's been a huge appetite of greed created in the go-go late '90s and companies are trying to meet what are obviously unrealistic expectations any way they can," he says (Callahan 2003).

Also familiar is this refrain: "If you go to conferences, you'll hear CEOs say, 'That's not a big deal. Everybody does it'" (Callahan 2003). The important point not to be lost here given the examples that fall outside the boundaries of what is considered legal is that even if corporations are operating within communal norms of the market, the process and results may still be catastrophic. Individual health insurance entities in the United States, for example, may operate legally and ethically but the entire configuration of the health insurance industry organized for profit only allows expensive coverage for a fraction of the population. A perpetual focus on examining the bark of specific trees hinders a recognition that the forest is on fire. A recognition of fraud as endemic to the health care industry as to the larger corporate culture need not distract us from a more basic question of whether market fundamentalism is compatible with healthy populations. Is a mantra of "to have lunch or be lunch" compatible with creating a context for healthy people?

Given the significance of "income and social status" and "social gradients" as significant determinants of health both in themselves and as intertwined as conditions of possibility for other listed health determinants, I would like to highlight here the importance of growing income and wealth inequalities arising from neoliberalism's logic

and the dynamics of globalization. The gap between rich and poor is ever widening.<sup>235</sup> The poorest 20% of the world's people saw their share of global income decline from 2.3% to 1.4% over the past 30 years. Meanwhile, the share of the richest 20% rose from 70 to 85% (United Nations Development Programme 1996). In 1960 the top fifth of income earners had 30 times the income of the poorest fifth--in 1997, 74 times as much (United Nations Development Programme 1999: 36).

Income inequality within countries has also increased. Paul Ryscavage's analysis suggests that from 1947 to 1973 there was rapid income growth and stable income inequality in the United States. From 1973 to 1996, there was slow income growth and rising inequality (1999: 45-80). Census Population Survey data show a Gini coefficient<sup>236</sup> that generally declined between 1947 and 1968 suggesting welfare state policies were successful at decreasing income inequality and redistributing wealth. Between 1968 and 1998 this trend reversed, as rising Gini coefficients tracked rising income inequality (Jones and Weinberg 2000: 1).

One way to visualize growing income disparities in the United States over time is to consider Table 4.1 that compares largest American fortunes with median figures:

**Table 4.1 Comparison of Largest American Fortunes with United States Median, Selected Years 1790-1999\***

Year	Size of largest fortune	Name	Median family or household wealth	Ratio of largest fortune to median
1790	\$ 1 million	Elias Derby	\$250	4000:1
1830	\$6 million	Stephen Girard	\$350	17,000:1
1868	\$40 million	Cornelius Vanderbilt	\$500	80,000:1
1890	\$200 million	William. H. Vanderbilt	\$540	370,000:1
1912	\$1 billion	John D. Rockefeller	\$800	1,250,000:1
1921	\$1 billion	John D. Rockefeller	\$1,250	800,000:1
1940	\$1.5 billion	John D. Rockefeller	\$1,750	850,000:1
1962	\$1 billion	Jean Paul Getty	\$7,200	138,000:1
1982	\$2 billion	Daniel Ludwig	\$33,300	60,000:1
1992	\$8 billion	Sam Walton	\$43,200	185,000:1
1995	\$11 billion	Bill Gates	\$45,900	240,000:1
1999	\$85 billion <sup>b</sup>	Bill Gates	\$60,000	1,416,000:1

a. Data adapted from (Phillips 2002: 38)

b. This figure is still compelling even though [www.forbes.com](http://www.forbes.com) listed Bill Gates's fortune in 1999 to be \$90 billion.

If indeed "numbers are another form of poetry" (Stone 1997: 163), then Table 4.2 is another verse of the "rich get richer and the poor get poorer":

**Table 4.2 Household Shares of Aggregate Income by Fifths of the Income Distribution in the United States, Selected Years, 1967-1998\***

Year	Lowest	Second	Middle	Fourth	Highest	Top 5%
1998	3.6	9.0	15.0	23.2	49.2	21.4
1997	3.6	8.9	15.0	23.2	49.4	21.7
1996	3.7	9.0	15.1	23.3	49.0	21.4
1995	3.7	9.1	15.2	23.3	48.7	21.0
1994	3.6	8.9	15.0	23.4	49.1	21.2
1993	3.6	9.0	15.1	23.5	48.9	21.0
Changes	Made to	Data	Collection	Methods		
1992	3.8	9.4	15.8	24.2	46.9	18.6
1991	3.8	9.6	15.9	24.2	46.5	18.1
1990	3.9	9.6	15.9	24.0	46.6	18.6
1985	4.0	9.7	16.3	24.6	45.3	17.0
1980	4.3	10.3	16.9	24.9	43.7	15.8
1975	4.4	10.5	17.1	24.8	43.2	15.9
1970	4.1	10.8	17.4	24.5	43.3	16.6
1967	4.0	10.8	17.3	24.2	43.8	17.5

\*Source: (Jones and Weinberg 2000: 4)

Canada's Gini Index increased slightly from 0.286 in 1981 to 0.289 in 1987. This may be contrasted with the greater income inequality in the United States shown by a Gini Index of 0.309 in 1979 that increased to 0.341 in 1986 (Ryscavage 1999: 173). A growing body of literature has been exploring income and wealth inequities as a health determinant.<sup>237</sup> David Lynch and colleagues' study of 282 U.S. metropolitan areas, for example, found that greater income inequality was associated with higher death rates *at all income levels* (1998). What would happen if social gradient was ever taken seriously as a health determinant with profound consequences for morbidity and mortality that could be ameliorated by deliberative human agency?

Lynch and Kaplan from the University of Michigan subsequently teamed up with some scholars from the University of British Columbia and Statistics Canada to compare income inequality and mortality in the United States and Canada. Analyzing 50 U.S. states, 282 U.S. metropolitan areas, 10 Canadian provinces, and 53 Canadian metropolitan areas, they found Canadian provinces and metropolitan areas had both lower income inequality and lower mortality. In age grouped regression models that combined Canadian and American metropolitan areas, income inequality was a significant explanatory variable for all age groups except the elderly. The effect was largest for working age populations in which a hypothetical 1% increase in the share of income to the poorer half of households would reduce deaths by 21 per 100,000 (Ross et al. 2000: 898). In contrast with the United States, income inequality was not significantly associated with mortality in Canada at the provincial or metropolitan area levels. The authors conclude that the Canadian findings that run counter to the "increasingly noted association at the societal level" may be a result of "different ways in which social and economic resources are distributed in Canada and the United States" (Ross et al. 2000: 898). In other words, programs of the welfare state that redistribute income and invest in



public goods such as education, libraries, parks, transportation, and health care may ameliorate some of the negative effects of income inequality on health.

Market fundamentalism is not sustained by its affinity with some “natural” order, or by its intellectual rigor, or by accident. Commodifying human beings, nature, and even the divine needs sparkle and spin. Johann Tetzl marketed an increase in the price of indulgences in the early sixteenth century by a singing commercial: “when the coin into the platter pings, the soul out of purgatory springs” (Cox 1999). In time persuasion became an industry with religious aspirations. Ivy Lee, one of the early founders of public relations saw these possibilities:

Public relations, he declared in 1923, was nothing less than the “*art of steering heads inside...the secret art of all the other arts, the secret religion of all religions.*” This art, he proclaimed apocalyptically, held “the secret” by which “a civilization” might be preserved and “a successful and permanent business” built (Ewen 1996: 132).<sup>238</sup>

A conservative estimate of the amount of money spent each year in the United States on corporate public relations is \$10 billion (Rampton and Stauber 2001: 26). Instances of “checkbook science”<sup>239</sup> are often orchestrated by public relations firms such as the top five healthcare public relations firms of Edelman, Ruder Finn, Medical Action Communications Ltd., Noonan Russo/Presence, and Shire Health Group (Burton and Rowell 2003: 4). Public relations is differentiated from advertising by the use of “third-party technique” which utilizes trusted key figures or organizations to mold and sway public opinion (Rampton and Stauber 2001: 19).

A generic example of this technique was used in 1998 when Edelman developed a campaign for Microsoft to head off new antitrust investigations that included “the planting of articles, letters to the editor, opinion pieces to be commissioned by Microsoft top media handlers but presented by local firms as spontaneous testimonials.” A year after the controversy from this leaked memo faded, an “Open Letter to President Clinton from 240 Economists” appeared as full-page advertisements in the *New York Times* and

*Washington Post*. The ads were paid for by the Independent Institute, self-described as “a non-profit, non-partisan, scholarly research and educational organization.”<sup>240</sup> It was later revealed that Microsoft was the largest outside donor to the Independent Institute; in 1999, Microsoft provided 20% of the Independent Institute’s operating budget (Rampton and Stauber 2001: 8-10).

The strategic use of the public relations industry to further the interests of organized medicine has been illustrated in Chapter Three with historical examples of orchestrated campaigns to cast universal health insurance as “socialized medicine” in the United States and Canada. Chapter Five will provide additional examples of a nexus between the global pharmaceutical industry, the public relations industry, and physicians. The power of the public relations industry to narrow public discourse on issues that threaten the bottom lines of its clients may be increased by deregulation of the telecommunications industry. Ben Bagdikian has traced the consolidation of media ownership into fewer corporations wielding more influence from fifty corporations in 1984 to twenty three in 1992 to ten in 1997 to six firms that dominate all American mass media in 2000.<sup>241</sup>

Chapter Five will continue to explore the themes of trade liberation, privatization, and deregulation using the pharmaceutical industry as an illustration of market fundamentalism. The global pharmaceutical industry is a particularly fascinating exemplar of “cowboy economics” disguised as a force for global health in that its reiterative response seems to have a protective effect in a variety of contexts. Consistent with George Bernard Shaw’s argument of “science at the prow and commerce at the helm” in Chapter Three, we will also examine evidence that undergirds a critique of physicians as the “Arthur Andersens of Medicine” (Mallaby 2002) in the following chapter.

CHAPTER FIVE  
WILLIE SUTTON AND VIAGRA: GLOBAL PHARMACEUTICALS AS FRONTIER OF  
OPPORTUNITY

“If Willie Sutton were alive today he would be counterfeiting Viagra because that’s where the money is.” Mark McClellan, MD, PhD, speaking as Commissioner of the Food and Drug Administration<sup>242</sup>

“What’s breaking into a bank compared with founding a bank?” Bertolt Brecht (1898-1956), *The Threepenny Opera*, Act Three<sup>243</sup>

This chapter will argue Willie Sutton might be tempted to “go legit” and become chief executive officer of Pfizer (which makes Viagra) or another global pharmaceutical company instead. Attentiveness to some of the key dynamics of the pharmaceutical industry provides an opportunity to revisit the themes of the non-innocence of health and medicalization from chapter two, the science and commerce nexus from chapter three, as well as physician complicity with transnational corporations. The first section will give a brief account of changing pharmaceutical legislation in Canada as illustrative of inherent tensions between neoliberal and regulatory regimes. The second section of this chapter will discuss pharmaceutical products as increasingly great expenditures out of the public’s purse even as they are described as “windfalls” for the private sector. The third section will revisit the instrumental use of health as the drug industry markets hope in a bottle. The fourth section will examine some of the evidence that prompts observers to term some physicians as “the Arthur Andersens of Medicine.” The fifth section will explore reiterative drug discourse by considering examples from Senator Estes Kefauver’s investigation into the drug industry in the early 1960’s, the joint hearing on the Comprehensive Child Immunization Act of 1993, and debates common in 2003 concerning the importing of prescription drugs from Canada into the United States as well as Medicare reform. Concluding remarks will ponder our fascination and its consequences with the Willie Suttons of the world rather than following Brecht’s lead of thinking about the banks instead.

## Brief Introduction to Global Trade's Impact on Canadian Pharmaceutical Policy

While Canada does not have any transnational pharmaceutical companies that use Canada as their base, the influence of the global industry over Canadian pharmaceutical policy has increased over the last two decades. Dr. Joel Lexchin<sup>244</sup> attributes the convergence of their influence to three factors: the importance of intellectual property rights to the trade agenda of the United States, Canada's participation in the bilateral and multilateral trade agreements, and dynamics related to Canadian unity<sup>245</sup> (2001: 34). It is interesting to note that a key player in getting intellectual property rights and patent protection for pharmaceuticals to the top of the American agenda was the president of Pfizer, Ed Pratt. In 1981 Ronald Reagan appointed Pratt<sup>246</sup> to head his private-sector trade advisory panel. Drug patents was a key item discussed at the "Shamrock Summit" between Reagan and Mulroney in 1985 and in that same year Canada's drug legislation was listed as a "trade irritant" by the U.S. Representative (Lexchin 2001: 34).

The first blow to "compulsory licensing"<sup>247</sup> that is pertinent to this narrative came when the Mulroney government enacted Bill C-22 in 1987. This legislation gave companies introducing a new drug a minimum of seven years of protection from compulsory licensing (Lexchin 2001: 35). Although it was denied by the federal government, it was widely acknowledged by trade experts and reported in the newspapers that passage of C-22 was necessary to win Washington's approval of the Canada-U.S. Free Trade Agreement (Fuller 1998: 191). Bill C-91 or the "Merck Bill,"<sup>248</sup> passed in 1993, abolished compulsory licensing and gave transnational companies twenty years of patent protection for their products. Lexchin notes Canadian eagerness to sign the North American Free Trade Agreement and be in compliance with the General Agreement on Tariffs and Trade "coincided with the interests of the drug industry" (2001: 35).

As with the public relations campaigns funded by physicians against universal health insurance in the United States and Canada described in Chapter Three, the pharmaceutical industry mounted a “multi-faceted, all-fronts lobby” (Rachlis and Kushner 1994: 148). In addition to buying services “from nearly every lobby firm in Ottawa,” universities,<sup>249</sup> voluntary organizations,<sup>250</sup> and professional organizations were approached for support. Active supporters of Bill C-91 included the Canadian Medical Association, The Canadian Society for Clinical Investigations, and The Canadian Federation of Biological Societies. In terms of “pay-back” for supporters—the Medical Research Council received twenty million dollars for a “partnership” doing biomedical research. When Brian Mulroney retired from politics he rejoined the Montreal law firm of Ogilvie Renault that advised Merck during the Bill C-91 debate (Rachlis and Kushner 1994: 148-149).

Deregulation of the pharmaceutical industry in terms of “pay-out” has been significant as witnessed by Table 5.4. While the Consumer Price Index in Canada increased by 23.1% from 1987 to 1996, the costs of prescription drugs rose by 93% (Fuller 1998: 191).<sup>251</sup> As costs increase, consumer protection has decreased as the Canadian government reduced funding to the Health Protection Branch. Funding for this branch of Health Canada responsible for drug monitoring and approvals decreased from \$237 million in 1993-1994 to \$136 million in 1996-1997 to \$118 million projected for 1999-2000 (Lexchin 2001: 38). This regulatory agency turned to the drug companies for replacement funding to keep operating and increased their reliance on industry self-regulation rather than direct oversight. The combination of industry funding and “a civil service with a bias for uncritical cooperation with industry” has led to a reorientation of Health Protection Branch policy that is increasingly favorable to the pharmaceutical transnationals (Lexchin 2001: 38). This is consistent with the situation of the Food and Drug Administration in the United States which has also been described as “chronically

underfunded” and increasingly dependent on user fees paid by the companies whose products are being regulated (Coleman 2003).<sup>252</sup> It should be noted that even with perceived decreased regulation there remains a chronic tension between forces that would like to increase the speed at which new pharmaceutical products become available and those advocating for increased vigilance over product safety.<sup>253</sup>

### Pharmaceutical Products as Public Cost Drivers and Private Revenue Enhancers

The pharmaceutical industry has been described as “one of the most globalized sectors in an increasingly globalized health-care industry” (Fuller 1998: 205). This sector is vital as prescription drugs are a major cost driver of escalating health care expenditures in the United States and Canada.

**Table 5.1 Distribution of Health Expenditures by Percentage in the United States by Type of Service, 1990 and 2000\***

Type of Service	1990	2000
Hospital Care	36.5	31.7
Physician/ Clinical Services	22.6	22.0
Prescription Drugs	5.8	9.4
Nursing Home Care	7.6	7.1
Home Health Care	1.8	2.5
Other personal Health Care	13.3	14.3
Other Health Spending	12.4	13.0

\*Adapted from (Kaiser Family Foundation 2002: 10)

While hospital care and physician/ clinical services make up the largest share of health expenditures, their percentages declined from 1990 to 2000 while the percentage for prescription drugs increased.

**Table 5.2 Annual Percentage Change in Selected Health Expenditures for the United States, Actual and Projected for Years 1980 to 2012\***

(Average Annual Percent Change from Previous Year Shown)

Year	Hospital Care	Physician/Clinical Services	Prescription Drugs
1980	--	--	--
1990	9.6	12.8	12.8
1998	5.1	6.3	10.1
1999	4.1	5.2	19.7
2000	5.8	6.9	16.4
2001	8.3	8.6	15.7
Projected	Projected	Projected	Projected
2002	7.4	6.5	14.3
2003	5.5	6.8	13.4
2004	6.0	6.9	12.4
2005	6.3	6.7	11.7
2006	6.2	7.2	11.1
2007	6.1	7.1	10.6
2008	6.0	7.0	10.3
2009	5.9	7.0	9.9
2010	5.7	6.7	9.6
2011	5.6	6.5	9.4
2012	5.6	6.5	9.2

\*Source: Adapted from (Centers for Medicare and Medicaid Services 2003)

The annual rate of change of nearly 20% for drugs in 1999 eclipsed other sectors. These percentages translate into billions and even trillions of dollars:

**Table 5.3 National Health Expenditure Amounts, United States, 1980-2012\***

(Amount in Billions of Dollars)

Year	National Health Expenditures	Hospital Care	Physicians/Clinical	Prescription Drugs
1980	245.8	101.5	47.1	12.0
1990	696.0	253.9	157.5	40.3
2000	1,310.0	416.5	288.8	121.5
Projected	Projected	Projected	Projected	Projected
2006	2,044.2	649.4	436.4	254.0
2012	3,079.8	860.0	646.4	445.9

\*Source: Adapted from (Centers for Medicare and Medicaid Services 2003)

As in the United States, hospital care in Canada makes up the largest category of health care spending, accounting for \$35 billion in 2002 (Canadian Institute for Health

Information 2003: 69).<sup>254</sup> The percentages for hospitals and physicians' services has been decreasing in Canada as in the United States, while the percentage on drugs has increased. Of note, however, is that in 1997 the percentage of total health expenditures spent on drugs surpassed that spent on physicians' services for the first time, as will be noted in Table 5.4. This 16.2% of total health expenditures for drugs came to about \$18 billion dollars in 2002 (Canadian Institute for Health Information 2003: 69). Total health care expenditures in Canada in 2002 was \$112 billion (Canadian Institute for Health Information 2003: 65).

Expenditures for some are revenues for others.<sup>255</sup> The global pharmaceutical industry generated revenues in excess of \$364 billion in 2001 (Burton and Rowell 2003: 4). The leading drug industry market analyst company ranks "the top five corporations" in the year ending June 2003 in order as: Pfizer, GlaxoSmithKline, Merck, AstraZeneca, and Novartis (IMS Health). The drug industry is the most profitable sector in the United States, as measured by median return on revenue, for each of the last 11 years (Families USA Foundation 2002: 13). Tables 5.5, 5.6 and 5.7 that illustrate these points follow.



**Table 5.4 Shifting Allocations of Health Care Spending in Canada  
Percentages of Total Health Expenditures by Sector, Selected Years 1975-2002\***

Year	Hospitals	Drugs	Physicians	Other <sup>a</sup>
1975	44.7	8.8	15.1	31.4
1980	41.9	8.4	14.7	35.0
1985	40.8	9.5	15.2	34.5
1986	40.7	10.2	15.4	33.6
1987	40.5	10.5	15.7	33.4
1988	40.0	10.8	15.6	33.5
1989	39.6	11.1	15.2	34.1
1990	39.0	11.4	15.2	34.4
1991	38.7	11.6	15.4	34.3
1992	38.2	12.2	15.0	34.6
1993	37.4	12.8	14.7	35.1
1994	35.9	12.9	14.7	36.6
1995	34.6	13.6	14.4	37.5
1996	34.0	13.9	14.4	37.7
1997	33.3	14.5	14.2	37.9
1998	33.0	15.0	14.0	38.0
1999	32.0	15.0	13.6	39.4
2000	32.1	15.4	13.3	39.2
2001	31.3	15.9	13.3	39.5
2002	31.3	16.2	13.4	39.1

\*Source: Adapted from National Expenditures Database, (Canadian Institute for Health Information 2003: 54).

a. "Other" includes capital, administration, public health, other health professionals, other institutions, and other health spending.

**Table 5.5 Profitability Among Pharmaceutical Industry Compared With Median<sup>a</sup> for All Fortune 500 Firms, 1991-2002\***

Year	Median % Return All Fortune 500 Firms	% Return Pharmaceutical Industry
1991	3.2	12.8
1992	2.4	11.5
1993	2.9	12.5
1994	4.6	16.1
1995	4.8	14.4
1996	5.0	17.1
1997	4.9	16.1
1998	4.4	18.5
1999	5.0	18.6
2000	4.5	18.6
2001	3.3	18.5
2002	3.0	17.0

\*Data for the years 1991-2001 obtained from (Families USA Foundation 2002: 14). Data for 2002 obtained from (Kaiser Family Foundation 2003: 2).

a. Percent shown is the median percent net profit after taxes as a percent of firm revenues for all firms in the industry.

Not coincidentally, prescription drug prices are higher in the United States than in other industrialized countries. The average foreign-to-American price differences for all patented drug products in 1999 showed that Italy was 49%, France 51%, Canada 57%, Sweden and Germany 60%, United Kingdom 64%, and Switzerland 65% compared with 100% for the United States (Public Citizen 2002: 23). European countries use a variety of regulatory methods such as individual price controls, reference price system, generic pricing policy, and measures to encourage generic pricing in order to control costs (Huttin 1999). Canadian analysts note that generic drug prices are higher in Canada than in some other countries—for example, generic drug prices are 68% lower in New Zealand and 26% lower in Germany.<sup>256</sup> The spending per capita on pharmaceuticals in 2000 (in US \$ PPP) was \$385 for Canada and \$556 for the United States in the context of an OECD median of \$262 (Anderson, Reinhardt et al. 2003: 94).

*Forbes* ranking of top global pharmaceutical firms' sales, profits, and assets based outside the United States and within the United States may be found in Tables 5.6 and 5.7 respectively:

**Table 5.6 Pharmaceutical Companies Based Outside of the United States as Ranked by *Forbes*, International 500, 2003\***

(amounts are in millions of dollars)

Name	Year	Revenue	Net Income	Assets	International 500 Rank	Headquarters
GlaxoSmithKline		31,845	5,907	29,219	67	U.K.
Novartis Group		20,795	4,692	43,370	119	Switzerland
Aventis		19,408	2,048	31,013	127	France
Roche Group		19,071	-2,583	45,580	133	Switzerland
AstraZeneca		17,841	2,836	20,951	139	U.K.
Takeda Chemicals		8,576	2,228	17,112	315	Japan
Merck KGaA		7,033	191	7,674	375	Germany
Sanofi-Synthelabo		7,010	1,655	8,759	376	France

\*Source: [www.forbes.com](http://www.forbes.com) Accessed September 5, 2003

**Table 5.7 Pharmaceutical Companies Listed in Forbes 500, Years 2000, 2003**

(amounts in millions of dollars)

Name	Year	Sales	Profits	Assets	Forbes 500 Rank	Headquarters
Merck	2003	51,790	7,149.5	47,561	16	New Jersey
Merck	2000	32,714	5,890	35,634	22	
Pfizer	2003	32,373	9,536.0	44,876	20	New York
Pfizer	2000	16,204	3,179	20,574	48	
Johnson & Johnson	2003	36,298	6,597.0	40,556	22	New Jersey
Johnson & Johnson	2000	27,471	4,167	29,163	33	
Abbott Laboratories	2003	17,685	2,793.7	24,259	48	Illinois
Abbott Laboratories	2000	13,178	2,446	14,471	67	
Wyeth	2003	14,584	4,447.2	25,995	49	New Jersey
Wyeth	2000	N/A			---	
Bristol-Myers Squibb	2003	18,119	1,895.0	24,905	51	New York
Bristol-Myers Squibb	2000	20,222	4,167	17,114	45	
Eli Lilly	2003	11,078	2,707.9	19,042	60	Indiana
Eli Lilly	2000	10,003	2,721	12,825	72	
Pharmacia <sup>a</sup>	2003	13,993	1,485.0	17,781	65	New Jersey
Pharmacia & Upjohn	2000	7,253	803	10,698	---	
Schering-Plough	2003	10,180	1,974.0	14,136	88	New Jersey
Schering-Plough	2000	9,176	2,110	9,375	92	
Amgen	2003	5,523	-1,391.9	24,456	197	California
Amgen	2000	3,340	1,096	N/A	---	
Caremark Rx	2003	6,805	781.4	1,913	263	Alabama
Caremark Rx	2000	3,308	N/A	N/A	---	
Forest Laboratories	2003	2,022	537.8	2,607	276	New York
Forest Laboratories	2000	N/A	N/A	N/A	---	

\*Source: [www.forbes.com](http://www.forbes.com) Accessed September 5, 2003

a. Pharmacia was acquired by Pfizer in April 2003.

While rankings differ among various industry analysts depending on timeframe used and whether one is looking at market share, sales, profits, or assets—the important point is that serious money is at stake. From 1996 to 2001, shareholders in the pharmaceutical industry received an annual rate of return of 18.4%, twice the 9.2% median return to shareholders for the Fortune 500 (Families USA Foundation 2002: 13). High profits did not necessarily translate into high corporate taxes in that pharmaceutical companies, in step with other U.S. corporations, are increasingly setting

up subsidiaries in offshore tax havens to reduce federal tax bills.<sup>257</sup> Pfizer, for example, has 30 subsidiaries which makes it one of 24 companies with the most subsidiaries in offshore tax havens (Anderson, Cavanagh et al. 2003: 19).

Significant compensation for industry executives is another incentive for being attentive to the “bottom line.” Chief executive officers of the top ten prescription drug makers averaged \$3.3 million each in salary in 2000 (Public Citizen 2002: 34). Raymond Gilmartin, CEO of Merck, received a 3.5% increase in salary and bonus from 2001 to 2002 (\$2,983,300). Pfizer’s CEO, Henry McKinell, had a 23.5% increase (\$5,309,200) in salary and bonus from 2001 to 2002 (Wall Street Journal/Mercer Human Resource Consulting 2003: 12). What might have captured Willie Sutton’s imagination, however, are stock options for CEOs. By poring over audited annual financial reports submitted to the Securities and Exchange Commission, the Families USA Foundation compiled some instructive data on total executive compensation as shown in Table 5.8.

As indicated in Table 5.8, chief executive officers for Bristol-Myers Squibb, Merck, and Pfizer respectively had “total compensation” in 2001 of \$74,890,918, \$2,890,988, and \$23,759,405 each plus total unexercised stock options for \$76,095,611, \$93,256,774, and \$56,491,000. While the executives of Pfizer are probably not in danger of needing to eat cat food during their retirement years, general Pfizer employees may not fare so well. With a pension deficit of \$2,555,000,000, Pfizer is one of the thirty companies in the United States with the largest pension deficits (Anderson, Cavanagh et al. 2003: 11).

**Table 5.8 Executive Compensation, BristolMyersSquibb, Merck, and Pfizer, 2001\***

Company	Bristol-Myers Squibb	Merck	Pfizer	Pfizer
Executive Name	C.A. Humbold	R. Gilmartin	W. Steere	McKinnell
Title	Chair and CEO <sup>a</sup>	Chair, CEO, President	Former Chair <sup>b</sup>	Chair & CEO
Salary	1,111,367	1,383,338	808,000	1,516,667
Bonus	2,593,683	1,500,000	1,616,000	2,780,800
Other Annual Compensation	89,300 <sup>c</sup>	Not reported	22,203 <sup>d</sup>	33,655
Restricted Stock Awards	0	Not reported	0	0
Long Term Incentive Payouts	907,000	Not reported	0	7,920,000
All Other Annual Compensation	50,012 <sup>e</sup>	7,650 <sup>f</sup>	549,440 <sup>g</sup>	117,743
Value of Shares Acquired on Exercise	70,139,556	0	25,268,842	11,390,540
Total Compensation	74,890,918	2,890,988	28,264,282	23,759,405
Value of Unexercised In-The-Money Options SARS (E)	59,828,145	64,649,250	49,876,119	29,307,744
Value of Unexercised In-The-Money Options SARS (U)	600,258	3,473,750	10,310,900	4,371,990
Grant Date Present Value	15,667,208	Not reported	Not reported	Not reported
Potential Realizable Value at 5% Growth	Not reported	25,133,774	0	22,811,266
Total Unexercised Stock Options	76,095,611	93,256,774	60,187,019	56,491,000

\*Source: Adapted from (Families USA Foundation 2002: 29-32)

- a. Mr. Humbold resigned from his position as CEO on May 1, 2001. He resigned as chair on Sept. 12, 2001.
- b. Mr. Steere served as chair until April 30, 2001. (Families USA Foundation 2002: 32)
- c. Represents personal use of company aircraft and payments for financial counseling.
- d. Amount shown represents tax payments made on behalf of officer relating to his use of company transportation and personal financial counseling.
- e. Consists of matching contributions to the Savings and Investment Plan and the Benefit Equalization Plan.
- a. Company contribution to the Employee Savings and Security Plan.
- b. Amount represents company matching funds under the Pfizer Savings Plan and related supplemental plans.

## Health as an “Operational Term” of Pharmaceutical Marketing

This information about financial aspects of the pharmaceutical industry helps to set the context to appreciate Pfizer’s mission statement and purpose:

### **Pfizer’s Mission**<sup>258</sup>

We will become the world's most valued company to patients, customers, colleagues, investors, business partners, and the communities where we work and live.

### **Pfizer’s Purpose**

We dedicate ourselves to humanity’s quest for longer, healthier, happier lives through innovation in pharmaceutical, consumer and animal health products.

While value may be attributed in a variety of ways, the function of a for-profit corporation is to earn a high rate of return for its investors as discussed in Chapter Four. The quest for health is one of the instrumental values used by Pfizer to accomplish its mission of profitability. GlaxoSmithKline’s “mission is to improve the quality of human life by enabling people to do more, feel better and live longer.”<sup>259</sup> The mission of Merck is “to provide society with superior products and services by developing innovations and solutions that improve the quality of life and satisfy customer needs, and to provide employees with meaningful work and advancement opportunities, and investors with a superior rate of return.”<sup>260</sup> Whether explicitly highlighted or implicit within an appeal to enhancing the quality of life, health is a non-innocent marketing tool. Merck’s tag line of “committed to bringing out the best in medicine” makes a further specific link between the agenda of the company with medicine as drug and medicine as the premier profession authorized to legitimate pharmaceuticals’ use.

Carl Elliott argues that “the genius of much of today’s pharmaceutical marketing” is that it looks like science rather than marketing (2003: 124-125). The genius of marketing is such that baldness, shyness, and face wrinkles have been cast as

legitimate medical problems in need of expensive amelioration while millions of people die from poverty. A classic example of this is human African trypanosomiasis or sleeping sickness which is a “public health problem of epidemic proportions in many parts of rural Africa” (Stich, Abel, and Krishna 2002: 203). While access to drugs is only one component of health in Africa, finding and supplying medication to treat this disease has been a major challenge. Until recently there was only one drug available to treat stage 2 of this disease, melarsoprol, a compound containing arsenic that was associated with 4 to 12 per cent mortality (Stich, Abel, and Krishna 2002). In 1990 Marion Merrell Down (bought by Hoechst in 1995) announced that it had produced the first new medicine in 40 years for this disease, which kills about 40,000 people per year. Although it had few side effects unlike the other medications available and was effective, it was pulled from production because the economic return was too small (Silverstein 1999). Elflornithine is an antitrypanosomal drug that was originally a by-product of cancer research; it was withdrawn from production from 1995 to 2000 because of non-profit (Zumla 2002). North American production lines for this drug were reopened in 2001 as a cosmetic for depilatory creams. Protest by health organizations and media coverage suggesting the pharmaceutical industry was “not facing up to its humanitarian responsibilities” finally resulted in a “public private partnership” between Aventis, Bayer, the World Health Organization, and Médecins sans Frontières to assure production of five essential antitrypanosomal drugs for five years (Stich, Abel, and Krishna 2002: 205).

Thought to be unnecessary in the North and uncommercial in the South, there was not a single company manufacturing Streptomycin after mid-1991. In response to the reemergence of tuberculosis in inner cities in the United States, the FDA set up a task force “but it was two years before it prodded Pfizer back into the field” (Silverstein 1999). Pfizer does, however, have a research and development program for medications



that help pets with arthritis, anxiety, and dementia; in 1999 the FDA approved Pfizer's Anipryl for "canine cognitive dysfunction syndrome" (Silverstein 1999). In fact, creating new products for pets is a booming industry. Since 2000 the sale of weight control pet foods has grown by 25% to \$500 million per year, which makes it one of the fastest-growing segments in the \$12.5 billion pet food industry (Koerner 2003). The pet food industry's scientific motivation in researching this product line was captured by Dr. Pogrel of the Bishop Ranch Veterinary Center who said, "If you can make them live two years longer, that's two more years you can sell them pet food" (Koerner 2003). If only the people with sleeping sickness were a market for pet food maybe continuation of the antitrypanosomal drugs could be assured past a five-year window.

As a strategy to defamiliarize a normative marketing device draped in science, let us examine "disease management" for several of Pfizer's product lines in Exhibit 5.1. There are remarkable similarities between marketing products for people or their "companion animals" and for product lines with different target audiences. Website information is careful to stress the importance of the patient/doggy: physician/vet relationship even while socializing on "how to talk to your doctor," "what question to ask your vet," and reminding to ask for free samples. Just as consumers learn to "handle" their health care providers, the website is also generous with advice, tools, and resources that will allow health care providers to "manage" their patients. Their product is the fix that will solve the problem that the website will be sure to tell you is more drastic than you probably were aware. Photographs and testimonials that appeal to the most primal of emotions—love, sex, and fear—are juxtaposed with pragmatic action plans that include product consumption.

"Disease management" is a particularly effective marketing tool that depends on complicity between the medical profession and the pharmaceutical industry. In November of 1996, for example, Searle Canada (subsidiary of U.S. chemical manufacture

Monsanto, Inc.) launched the Arthritis Canada website, in partnership with the Arthritis Society of Canada and the Canadian Rheumatology Association. John Manley, the federal minister of industry who helped unveil the site, described it as a “model of public and private partnership, and the direct involvement of knowledgeable professionals” (Fuller 1998: 200). The website provided information about arthritis, treatments, medications, a “private area where rheumatologists can interact,” and a direct link to Seale Canada where patients can deposit their names and addresses in the corporation’s data bank (Fuller 1998: 200).

**Exhibit 5.1 A Product Line is a Product Line is a Product Line for Pfizer**

Brand Name	Celebrex	Rimadyl (NSAID)	Viagra
Generic Name	Celecoxib	Carprofen	Sildenafil Citrate
Website	www.celebrex.com	www.rimadyl.com	www.viagra.com
FDA approved	yes	yes	yes
Indications	human arthritis pain	canine arthritis pain	erectile dysfunction (ED)
Goals	"manage pain so you can celebrate"	"improve quality of life"	"rediscover their love lives"
"Facts"	1 in 6 Americans 43 million people	1 in 5 adult dogs 8 million dogs	Half of all men in USA between 40-70 yrs; "prescribed by more than 600,000 physicians worldwide"; "9 tablets dispensed every second"; 30 million men
Signs & Symptoms	What is arthritis? What is acute pain?	How to recognize dogs in pain generally & arthritis	What is ED? What causes it?
Testimonials		Owners & Vets	Success Stories from Men, Partners, Doctors
FAQs	Q & A with Mayo Clinic doctor	Other strategies: diet, exercise, massage, etc.	Answers to common questions
Checklist	Arthritis Symptom	Senior dog	Sexual Health Quiz
Technical	Prescribing Information	Prescribing Information	Prescribing Information
Consulting Advice	List of questions to ask your doctor	What to tell/ ask your vet	Tips for talking with your doctor & reminder to ask for free samples
Photographs	Cute older people, some with dogs	Cute dogs	Cute heterosexual couples, smiling individual men including doctor at www.viagraMD.com
Disease Management	Strides Patient Education Program		"Achieving Success with Viagra" for patients & extensive info for partners.
Treatment Guidelines	Am. College of Rheumatology Am. Pain Society Am. Geriatrics Society		Viagra Clinical Tools "Managing ED in your Practice" "ED Patient Screener" "Conversation Starters"

By March of 1999 the “disease management community” had its own association (Disease Management Association of America<sup>261</sup>) along with an official journal (*Disease Management*) that was started in 2002. Five years after Fuller’s description of the Arthritis Canada website<sup>262</sup> one can now visit an increasingly sophisticated portal with specific sections for patients and their families, rheumatologists, orthopedic surgeons, arthritis health professionals, and researchers/industry. From this main page, physicians may quickly access links to the Canadian Orthopedic Association, the Canadian Rheumatology Association, the Cochrane Musculoskeletal Review Group, the Institute of Musculoskeletal Health and Arthritis, and *The Journal of Rheumatology*. Allied health professionals working with people who have arthritis also have specific resources available from the Arthritis Health Professions Association.

Visitors to the “Arthritis Canada” portal who click on “patients and families” will be linked to the Arthritis Society of Canada website<sup>263</sup> which is “sponsored by an educational grant” from Pfizer. Pfizer notes that the Arthritis Society’s website “has become one of the most comprehensive health care sites in the world” and receives more than 36,000 visits per day.<sup>264</sup> One of the programs described on the website is the Arthritis Self-Management Program directed to patients and their families. For only “a small fee” due to sponsorship by Seale Canada, Pfizer Canada, community support, and volunteer leaders, patients may participate in a two hours per week for six week “health promotion” course to learn new information and increase skills. “Taking arthritis medications” and “working with your doctor and healthcare team” are constitutive elements of the curriculum so patients are essentially underwriting part of Pfizer’s costs to market Celebrex to themselves. Physicians are situated both as resources in the “Ask an Expert” section of this website and as target groups for education and marketing. The “Patient Partners® in Arthritis” program, sponsored by Pfizer, utilizes 150 people with

arthritis as educators to “more than 3,300 medical trainees” and “over 3,000 healthcare professionals” since 1996.

Moving beyond clinical “disease management,” a vibrant example of “academic capitalism”<sup>265</sup> may be found at the link for “researchers/industry” which opens into another website for the Canadian Arthritis Network.<sup>266</sup> Self described as “your gateway to arthritis research and development in Canada,” the Canadian Arthritis Network is a not-for-profit organization that grew out an “in-depth consultation with the arthritis community held by The Arthritis Society” in 1997.<sup>267</sup> The Canadian Arthritis Network received a four year, \$14.5 million grant from the federal Networks of Centers of Excellence program “in response to the need for a multi-disciplinary, collaborative approach to arthritis research.” The Canadian Arthritis Network is “one-stop shopping”:

One point of contact links you to leading Canadian arthritis researchers and clinicians, Canadian academic institutions, The Arthritis Society, pharmaceutical and biotechnology companies involved in arthritis, government organizations, and many of Canada’s brightest new arthritis researchers.<sup>268</sup>

For industries involved in “bringing an arthritis product to the market,” the Arthritis Network offers expertise “from the early development of a product to post marketing surveillance” with preclinical,<sup>269</sup> clinical,<sup>270</sup> and health research services.<sup>271</sup> Researchers are given opportunities to obtain “matching funds for a faculty position” and links with “leading arthritis R&D experts to gain cutting-edge skills.” In addition to a database of more than 130 “leading scientists and clinicians,” this entrepreneurial nexus includes academic and clinical partners from prestigious Canadian institutions,<sup>272</sup> and the corporate<sup>273</sup> sector as well as government and non-profit organizations.<sup>274</sup> Given the close working relationship between the Arthritis Society of Canada and the pharmaceutical industry in these various collaborative activities, it is perhaps not surprising that Denis Morrice, president and CEO of the Arthritis Society of Canada, should argue that the industry is perceived unfairly:

We have these huge multinational pharmaceutical companies coming into the motherhood of Canadian health care, and all we see is a clash. In fact, the pharmaceutical industry saves millions of lives and saves millions of people from suffering every day, and yet the public perception of these companies is almost as negative as toward the tobacco industry, which kills people (Commission on the Future of Health Care in Canada 2002: 4).

A mainstream view of the pharmaceutical industry that Morrice reiterates is that their beneficent product lines entitle them to compensation that will encourage continued investment in innovative, life-saving therapies. Drug industry commitment to helping people is reinforced by how the pharmaceutical companies represent themselves and their concern for the developing world. On its website Pfizer has a “Partnerships for a Healthier World” section with the tagline “because people in need should get the medicines that they need” and engaging photographs of patients from developing countries.<sup>275</sup> Merck features the African Comprehensive HIV/ AIDS Partnership in Botswana (funded by the Merck Foundation and the Bill and Melinda Gates Foundation in conjunction with the Government of Botswana) on its website along with a captivating picture of an African woman and child.<sup>276</sup> BristolMyersSquibb’s website features the “Secure the Future” campaign for the support of women and children with HIV/ AIDS that includes concern-evoking photograph of an unhappy looking grandmotherly figure and a forlorn child.<sup>277</sup> A magazine ad for Becton, Dickinson and Company also features faces of African patients, information on the International AIDS Vaccine Initiative, and slogans of “partners offering hope” and “helping all people live healthy lives.” The trope that goes along with beautifully photographed people in need purportedly saved by the pharmaceutical industry’s products is the claim that progress is expensive. A common figure that is cited to support the need for high pharmaceutical prices is the claim by drug companies that it costs \$802 million to research and develop a new drug (Public Citizen 2002: 46). This figure has more recently been supplemented with an estimate of \$900 million by an

industry funded study done by the Tufts Center for the Study of Drug Development (Ahlin 2003). Pharmaceutical industry leaders claim that they have “discovered and introduced over 700 new medicines” since Medicare was enacted (Iglehart 2003).

A less commonsensical account is that less than 10% of global spending on health research is devoted to diseases or conditions that account for 90% of the global disease burden (Global Forum for Health Research 2000). Of the 1,393 new chemical entities brought to market between 1975 and 1999, only 16 were for tuberculosis and tropical diseases as the pharmaceutical industry argues that research and development “is too costly and risky to invest in low-return neglected diseases” (Trouiller et al. 2002: 2188).

The chief executive officer of GlaxoSmithKline, Jean-Pierre Garnier,<sup>278</sup> explains:

You see, if you discover the ideal vaccine for malaria, you probably will never generate a profit with it. Some for-profit companies have been discouraged by this: How can you justify to your shareholders spending \$400 to \$800 million on a project that will never return a penny? After all, your shareholders didn't elect you to do philanthropic research only (Iglehart 2003).

A wave of mergers makes this even more important: as one industry watcher put it, “The bigger they grow, the more they decide that their research should be focused on the most profitable diseases and conditions” (Silverstein 1999). A former head of Merck (which controls 10% of the world market) Roy Vagelos said, “A corporation with stockholders can't stoke up a laboratory that will focus on Third World diseases, because it will go broke. That's a social problem, and industry shouldn't be expected to solve it” (Silverstein 1999). This statement makes it all the more interesting when we read accounts of Merck donating their serendipitous discovery of Mectizan to treat river blindness when they could not find a sponsor to underwrite the project. Part of Hawthorne's rationale for thinking of Merck as “the last good drug company”<sup>279</sup> is their motto: “We try never to forget that medicine is for the people. It is not for the profits. The profits follow, and if we have remembered that, they have never failed to appear.

The better we have remembered that, the larger they have been" (Hawthorne 2003: 17-18). When Hawthorne interviewed Vagelos about his decision to donate Mectizan, Vagelos did not mention the people with river blindness but focused on worker morale:

He talked about "the people at Merck. The research people and how disappointed they would be if the drug never reached the people that would benefit." Merck was going to discover and product innovative drugs, even if they were given away. Because great drug companies make drugs (Hawthorne 2003: 17)

Princeton economist, Uwe Reinhardt points out the inherent contradiction that drug companies face:

Americans want the drug companies to be competitive and price-orientated. But every time it actually behaves that way, we wring our hands and say, "How come you're not behaving like a Catholic non-profit hospital?" (Hawthorne 2003: 265-266)

While an expectation that the pharmaceutical industry should behave like nursing sisters may be unrealistic, there is still an association with health care that makes this industry distinct from many other commodities. Health care ethicist, Paul Reitemeier, describes the aura around pharmaceutical companies attributable to an association with health care as "the halo effect" (Hawthorne 2003: 265). This halo is deliberately polished by some industry spokespersons:

"How do I want people to know us?" PhRMA's president, Alan Holmer, asked rhetorically at the trade group's annual meeting in 2002. He answered himself: "By the essence of who we are: our legions of doctors, scientists and researchers dedicated to the defeat of disease and the celebration of life" (Hawthorne 2003: 266)

Another way of considering the essence of who they are is to examine whose diseases and whose lives are celebrated by the global pharmaceutical industry. Most of the "new" chemical entities, 68.7% (959 of 1,393), presented little or no therapeutic gain compared with what was already available (Trouiller et al. 2002: 2189).<sup>280</sup> Half the global drug sales are in the United States, with Japan and Europe accounting for another 37% (Burton and Rowell 2003: 1). Pfizer had eight drugs with sales over \$1 billion each in



2001 including, Lipitor (a lipid lowering agent), which sold \$6.4 billion (Families USA Foundation 2002: 13). For the year ending June 2003, Lipitor's sales were over \$8 billion (IMS Health).<sup>281</sup>

Families USA Foundation and Public Citizen both make the argument that drug companies tend to spend vastly more on marketing and administration than research and development. In 2001, Fortune 500 drug companies devoted 12.5% of their revenue to research and development, 18.5% of their revenue to profits, and 30.4% of their revenues to marketing and administration (Public Citizen 2002: 41).

**Table 5.9 Comparison of Revenues in 2001 Dedicated to Marketing & Administration, Research & Development, and Profits for Merck, Pfizer, and BristolMyersSquibb\***

Company	Revenues Millions of \$	Marketing & Administration	Research & Development	Profits
Merck	47,716	13.0%	5.15%	15.3%
Pfizer	32,259	35.0%	15.03%	24.1%
BristolMyersSquibb	21,717	18.5%	8.93%	24.2%

\*Source: (Public Citizen 2002: 43)

The U.S. Senate Special Committee on Aging (1991) found that many of the dollars claimed by manufacturers to be spent on research of new pharmaceutical products were actually spent on marketing research. Public Citizen disputes the widely cited \$802 million claim to research and develop a new drug; this non-profit advocacy group asserts that \$403 million is a more accurate reflection of a pre-tax estimate. Calculating in research and development tax cuts and subsidies, Public Citizen's after-tax estimate is a more modest \$240 million for new drug development (Public Citizen 2002: 46-47).<sup>282</sup> Even so, the pharmaceutical industry reports spending over \$30 billion in research and development in 2001 (Iglehart 2003). It is important to keep in mind that the drug trials done by and/or funded by the pharmaceutical industry make up the "actual new information" that the Food and Drug Administration "will ultimately use to decide whether or not to approve" new medications (Coleman 2003). Consistent with

documented conflicts of interest inherent in industry-sponsored research<sup>283</sup> an editorial in the *Lancet* recently accused AstraZeneca of sponsoring biased research into its new anticholesterol drug rosuvastatin (Crestor). Charging “weak data,” “adventurous statistics,” and “marketing dressed up as research,” the company’s tactics “raise disturbing questions about how drugs enter clinical practice and what measures exist to protect patients from inadequately investigated medicines” (Dyer 2003).

As of June 2003, the “five top drugs” were 1) Lipitor 2) Zocor 3) Norvasc 4) Losec and 5) Prevacid (IMS Health). Tables 5.10, 5.11, and 5.12 with slightly older but more detailed data reveal several trends that are of interest. The fact that 18 out of the 20 top drugs by dollar sales are brand rather than generic is a reminder of the importance of patent protection for pharmaceutical corporate profitability. HMSA Hawaii reminds its members that the average prescription cost for a generic drug is \$26 compared with \$75 for a brand-name drug.<sup>284</sup> A battle between companies seeking to make generic versions of Prilosec could drop prices by 90 percent in one year and is likely to cause huge legal challenges (Harris 2003f). Celebrex and Vioxx cost \$3.7 billion in 2000 whereas an equivalent number of prescriptions for the over-the-counter anti-inflammatory drug, ibuprofen, would have cost \$180 million (Mallaby 2002). Vioxx is less likely to cause gastric upset than ibuprofen but in the Spring of 2002 the Food and Drug Administration required labeling that informs patients of increased risk of heart attacks associated with Vioxx (Hawthorne 2003: 84). On September 30, 2004 Merck announced that it was pulling Vioxx from the market when a study revealed that chronic use of this drug doubled the risk of a heart attack compared with a placebo (Neilan 2004).

It is significant that 15 out of 20 top drugs by dollar sales were first marketed in the 1990s, 4 were first marketed in the 1980s, while Premarin came to market in 1964. Given the recent studies that have linked hormone replacement therapy with increased

risk for stroke, breast cancer, and dementia forty years after it first became available, it is noteworthy that 46.8 million prescriptions for this drug were dispensed in 2000. Investigators analyzing 548 drugs approved by the FDA from 1975 to 1999 discovered that more than 10% (n=56) had serious side effects not discovered on initial testing. Seldane (antihistamine) was available for thirteen years and Propulsid (to prevent gastrointestinal reflux) was on the market for six years. Both were withdrawn for increasing risk of cardiac arrhythmia (Josefson 2002). Propulsid was linked to the deaths of more than 110 people (Palmer 2003). Some of the drugs found to have dangerous side-effects share the same target market as the more popular products found in Tables 5.11 and 5.12. In addition to the antihistamine and gastric products mentioned above, a link between increased risk of suicide for teens taking Paxil has reignited concern and lawsuits about selective serotonin reuptake inhibitors for depression (Harris 2003b). In 2003 another serotonin reuptake inhibitor available since 1994, nefazodone (Serzone), was taken off the market in Europe and Canada for adverse drug reactions linked to severe liver toxicity (Canadian Press 2003). A recent study found that patients with bipolar disorder taking Depakote were 2.7 times more likely to commit suicide than those taking the older, cheaper drug, Lithium (Grady 2003). Bayer had to remove its drug to treat high cholesterol, Baycol, from the market in August 2001, after reports of deaths from a severe muscle-weakening side effect (Harris 2003a).

**Table 5.10 Top 20 Prescription Drugs Ranked by Dollar Sales, 2000\***

Rank	Product	Indication	Sales \$ millions	% Increase 1999-2000	Brand or Generic	Year First Marketed
1	Philosec (Astra-Merck)	Anti-ulcerant	4,620	10	B	1989
2	Lipitor (Pfizer/Warner Lambert)	Cholesterol-lowering	4,147	38	B	1997
3	Prevacid (TAP/Abbott)	Anti-ulcerant	3,147	34	B	1995
4	Zocor (Merck)	Cholesterol-lowering	2,789	21	B	1992
5	Prozac (Dista/Lilly)	Anti-depressant	2,665	4	B	1987
6	Celebrex (Pharmacia/Searle)	Anti-inflammatory	2,154	53	B	1999
7	Epogen (Amgen)	Anemia	2,060	12	B	1989
8	Zoloft (Roerig/Pfizer)	Anti-depressant	1,980	14	B	1992
9	Zyprexa (Lilly)	Anti-psychotic	1,905	27	B	1996
10	Procit (OrthoBiotech)	Anemia	1,864	55	B	1991
11	Paxil (GlaxoSmithKline)	Anti-depressant	1,844	22	B	1993
12	Glucophage (Bristol MyersSquibb)	Anti-diabetic Agent	1,803	38	B	1995
13	Norvasc (Pfizer)	Hypertension	1,713	16	B	1992
14	Claritin (Schering)	Antihistamine	1,686	10	B	1993
15	Vioxx (Merck)	Anti-inflammatory	1,518	309	B	1999
16	Augmentin (GlaxoSmithKline)	Antibiotic	1,360	17	B/G	1984
17	Pravachol (Bristol Myers Squibb)	Cholesterol-lowering	1,309	11	B	1991
18	Risperdal (Janssen)	Anti-psychotic	1,307	26	B	1994
19	Neurontin (Parke-Davis)	Anti-epileptic	1,280	18	B	1998
20	Premarin (Wyeth-Ayerst)	Hormone Replacement	1,174	38	B/G	1964

\*Source: (Kaiser Family Foundation 2001: 34)

**Table 5.11 Top 20 Prescription Drugs by Number of Dispensed Prescriptions, 2000\***

Rank	Product	Indication	# Dispensed (million)	Brand or Generic	Year First Marketed
1	Lipitor (Pfizer/ Warner Lambert)	Cholesterol Lowering	48.8	B	1997
2	Premarin (Wyeth-Ayerst)	Hormone Replacement	46.8	B/G	1964
3	Synthroid (Knoll)	Thyroid Replacement	43.5	B/G	1963
4	Hydrocodone w/ APAP (Watson)	Narcotic Analgesic	36.5	G	1977
5	Philosec (Astra-Merck)	Anti-ulcerant	32.1	B	1989
6	Norvasc (Pfizer)	Calcium Channel Blocker	30.8	B	1992
7	Glucophage (Bristol MyersSquibb)	Anti-diabetic Agent	27.4	B	1995
8	Albuterol (Warrick)	Bronchodilator	27.4	G	1982
9	Claritin (Schering)	Antihistamine	26.5	B	1993
10	Zoloft (Roerig/ Pfizer)	Anti-depressant	25.2	B	1992
11	Celebrex (Searle/ Pharmacia)	Anti-inflammatory	24.7	B	1999
12	Prevacid (TAP)	Anti-ulcerant	24.4	B	1995
13	Prozac (Dista/ Lilly)	Anti-depressant	24.1	B	1987
14	Paxil (GlaxoSmithKline)	Anti-depressant	24.0	B	1993
15	Trimox (Apothecon)	Antibiotic	23.4	G	1977
16	Zestril (AstraZeneca)	ACE Inhibitor (for hypertension)	22.6	B	1988
17	Zocor (Merck)	Cholesterol-lowering	22.4	B	1992
18	Prempro (Wyeth-Ayerst)	Hormone Replacement	22.3	B	1995
19	Zithromax (Pfizer)	Antibiotic	22.0	B	1986
20	Vioxx (Merck)	Anti-inflammatory	20.5	B	1999

\*Source: (Kaiser Family Foundation 2001: 35)

Only New Zealand and the United States allow advertising of prescription drugs directed at patients (Mintzes et al. 2002: 278). In the United States, spending on direct-to-consumer advertising tripled from \$791 million in 1996 to \$2,467 million in 2000 (Rosenthal et al. 2002: 500). In 1996, direct-to-consumer advertising was 8.6% of all promotional spending; in 2000, direct-to-consumer advertising increased to 15.7% of all promotional spending (Table 5.13). Much of the increased spending on direct-to-consumer advertising is due to growth in television advertising. Television advertising accounted for approximately 13% of direct-to-consumer advertising in 1994 while it made up over 60% of direct-to-consumer advertising in 2000 (Frank et al. 2002: 1). Pharmaceutical manufacturers are campaigning in the European Union and in Canada for relaxing of current regulatory environment as researchers warn of “patients’ requests for medicines as a powerful driver of prescribing decisions” (Mintzes et al. 2002: 279).

**Table 5.12 Prescription Drugs With the Most Direct-to-Consumer Advertising, 2000\***

Rank	Drug	Indication	DTC Advertising \$ millions	Top 200 Ranking
1	Vioxx	Anti-inflammatory	160.8	20
2	Prilosec	Anti-ulcerant	107.9	5
3	Claritin	Antihistamine	100.3	9
4	Paxil	Anti-depressant	92.1	14
5	Zocor	Cholesterol lowering	91.2	17
6	Viagra	Erectile dysfunction	89.8	45
7	Celebrex	Anti-inflammatory	78.8	11
8	Flonase	Asthma	78.1	50
9	Allegra	Antihistamine	67.0	31
10	Meridia	Weight loss	65.0	NR
	Total DTC	Spending	2,467.1	

\*Source: (Kaiser Family Foundation 2001: 33)

In keeping with the logic of generating need in order to create demand for surplus product in consumer societies (Leiss, Kline, and Jhally 1990), pharmaceutical companies use advertisement “to educate” consumers. Merck spent \$160.8 million in

2000 on direct-to-consumer advertising of its anti-inflammatory drug, Vioxx. This is more than PepsiCo spent on advertising Pepsi or Anheuser-Busch spent on advertising Budweiser. The increase in Vioxx sales accounted for 5.7% of the one-year increase in drug spending, more than any other drug (Public Citizen 2002: 27-28).

“Lifestyle” or “enhancement technologies” are among those drugs targeted for direct-to-consumer advertising. Of the 50 drugs most heavily promoted in 1999, 13 could be used for enhancement purposes (Elliott 2003: 119). From Table 5.12 three of the top ten most heavily advertised drugs to consumers (Paxil, Viagra, and Meridia) have been classified by Elliott as enhancement technologies.

Using “one of the most expensive and ribald advertising blitzes in drug industry history,” Levitra captured half of Viagra’s market share among new prescriptions a month after approval for sale by the Food and Drug Administration (Harris 2003g). While Pfizer used Bob Dole as its pitchman to “educate” the public about “a serious condition called erectile dysfunction, a phrase that was meant to be a euphemism for impotence” in 1998, executives marketing Levitra are “unapologetic about their attempt to corral healthy men into trying the drug” (Harris 2003g). Moving from medicalization to recreational use, it is not surprising that Bayer and GlaxoSmithKline, who jointly market Levitra, have “become a partner with the N.F.L” as they “plan to work together on a men’s health educational program” (Petersen 2003d). Pfizer sponsors Major League Baseball, the NASCAR driver Mark Martin, and has hired the soccer star, Pele, to “raise awareness of erectile dysfunction worldwide” (Petersen 2003d). Pfizer spent \$87 million to advertise Viagra in the United States in 2002 (Petersen 2003d) for sales in 2002 of \$1.7 billion (Harris 2003a). Analysts partly explain the vigor of the Levitra campaign with the observation that both Bayer and GlaxoSmithKline “badly need a successful product.” Bayer’s profitability never fully recovered from the withdrawal of Baycol and GlaxoSmithKline is facing generic competition to some of its biggest sellers, including

Paxil (Harris 2003a). Pfizer dominates marketing among physicians with 11,000 sales representatives but GlaxoSmithKline has 8,000 sales representatives and Bayer has 3,000 more (Harris 2003a).

The newest “Viagra-slayer” to enter the market is Eli Lilly and ICOS’s Cialis that is set to spend \$100 million in its first year to market its 36 hour duration product for romantics. If Viagra medicalized sex and Levitra emphasized sex’s recreational aspects, Cialis is more fluffy bathrobes than stiletto-heeled shoes as the tagline suggests: “when a tender moment turns into the right moment, you’ll be ready” (Arndt 2003). As these direct to consumer ads try to sell romance, Cialis’s competitors direct their marketing efforts to detailing physicians by raising the specter of side-effects that could involve “36 hours of misery” at \$3,000 lunches for physicians and their office staff (Arndt 2003).<sup>285</sup>

**Exhibit 5.2 Marketing PDE5 Inhibitors, Sex, and Romance**

	Viagra	Levitra	Cialis
US Introduction	April 1998	August 2003	November 2003
Maker	Pfizer	Bayer & GSK	Eli Lilly & ICOS
Product Claim	Lasts 4 hours	Lasts 4 hours	Lasts 36 hours
Key Message	Safe, reliable, the drug you can trust	It’s new. It’s hot. It’ll make you hot, too.	What’s the hurry? Take your time.
Ad Tagline	“Join the millions”	“Once you get in the zone, it’s good.”	“At the right moment, you’ll be ready.”
Sport Tie-In	Baseball	Football	Golf
Projected Yearly Sales in 2010	\$3 billion	\$1 billion	\$2 billion

\*Sources: projected yearly sales data is from (Naughton 2004) and all other product information is from (Arndt 2003).

“The Arthur Andersens of Medicine”

At the height of the Enron scandal Sebastian Mallaby (2002) made a scathing analogy between “trusted professionals—auditors—who turn out to be corrupt, damaging the whole economy” with “trusted professionals—doctors—who are likewise corrupt, with even more expensive consequences.” Citing evidence consistent with material to be presented in this section of Chapter Five, Mallaby characterized



physicians with professional conflicts of interest as the “Arthur Andersens of Medicine.” The following discussion is written with full cognizance of the many physicians who make difficult decisions every day with great integrity. At the risk of doing a disservice to them, it is important to explore this theme of conflict of interest all the more as our gratitude and esteem for the medical profession would dissuade us. Another disincentive to this consideration is also the offense that is taken by some physicians when their behavior is scrutinized. Ronald Regan’s dissociation between his policies and their actual effects as well as his righteous indignation when questioned seems to parallel the outrage demonstrated by some physicians when conflict of interest issues are raised.<sup>286</sup>

While direct-to-consumer advertising has been growing rapidly, it is important to remember that the vast majority of promotional spending (84.3%) spent in 2000 by the pharmaceutical industry was directed to health professionals. Changes from 1996 to 2000 by promotional activity as percentage of total promotions may be found in Table 5.13. Out of total promotional spending in 2000 of over \$15.7 billion, \$13.2 billion was spent on free drug samples (\$7.954 billion), office-based promotions (\$4,038 million), hospital-based promotions (\$765 million), and journal advertising (\$484 million) (Rosenthal et al. 2002: 500).

**Table 5.13 Promotional Spending by Pharmaceutical Manufacturers, 1996-2000\***

(Percent of Total Promotion)					
Activity	1996	1997	1998	1999	2000
Sampling <sup>287</sup>	53.5	55.0	52.9	52.1	50.6
Detailing <sup>288</sup>	32.8	30.6	32.5	31.1	30.6
Direct-to-Consumer Advertising <sup>289</sup>	8.6	9.7	10.6	13.3	15.7
Professional Journal Advertising <sup>290</sup>	5.0	4.6	4.0	3.4	3.1
Total Promotion	100	100	100	100	100
Total \$ Millions	9,164.3	10,990.6	12,473.8	13,867.6	15,708.2

\*Source: (Kaiser Family Foundation 2001: 31)

If Willie Sutton were to run a global pharmaceutical firm instead of robbing banks, he could depend on a significant number of physicians as collaborators in his mission to maximize profit. The symbiotic relationship between the profession of medicine and the pharmaceutical industry is so naturalized that it may be difficult to recognize or acknowledge the extent of the complicity. The commerce of the global pharmaceutical industry benefits from legitimation provided by biomedicine even as biomedicine has come to view the drug industry as an inevitable component of medical education, clinical care, and research as well as a routine part of the daily lives of many physicians.

Sometimes a pharmaceutical company subsidizes extraordinary breaks in the daily routine of physicians by funding overseas or tropical trips as “continuing medical education.” A Canadian current affairs television program highlighted the incentives of airfare, accommodation, and some meals provided by Boehringer Ingelheim to physicians and their spouses at a resort in Jamaica in return for attendance at seminars promoting their arthritis drug (CTV News Staff 2002). A Toronto rheumatologist, Dr. Wally Pruzanski, who has been on five or six drug-company sponsored trips, explained that he feels no obligation to the drug company. He said, “You have to understand that when we leave Toronto, and when we accept this kind of invitation, we are losing part of our practice. So we are sacrificing part of our income, in order to educate ourselves” (CTV News Staff 2002). Expressing remorse for his own drug company sponsored trip to Ireland, Canadian Medical Association President, Dr. Henry Haddad remarked that “I didn’t feel comfortable being wined and dined by the industry” but also noted that “The CMA is not a police. CMA has no role in enforcement. We can’t sanction physicians” (CTV News Staff 2002).<sup>291</sup>

As the American Medical Association specifies that physicians should not accept cash payments from drug companies,<sup>292</sup> the role of the industry is even more hotly

disputed when discussing cash rather than “gifts.” A firm called Time-Concepts<sup>293</sup> receives \$105 from drug companies for each time that a physician listens to a short sales pitch in his or her office (\$50 goes to the physician, \$5 goes to a charity of the doctor’s choice, and Time-Concepts retains \$50). Dr. Neal Moser signed up with this company as it “gave him a more efficient way to get the drug information he needed” while “the fee barely covered the cost of his time” (Spurgeon 2002). While at least this physician believes that he is barely being compensated to meet his educational needs, the president of Time-Concepts argued that participating physicians are actually being paid to “perform impact analysis on the marketing information and presentation skills of a representative” therefore all ethical guidelines are met or exceeded (Wooten 2002).

A Canadian firm, Biovail Corporation has recently caused some controversy<sup>294</sup> by its marketing dressed up as research practice of reimbursing U.S. physicians<sup>295</sup> up to \$1,000 (USD) for prescribing its drug, Cardizem LA, for at least eleven patients. A company spokesperson said that the effort was intended to “generate physician survey data, with respect to Cardizem LA, that will be published” (Zuckerman 2003b). Even some of the participating physicians doubt the validity of this data collection for clinical trials for publication:

“They can call it a study, but there’s no science with it whatsoever,” asserts George Massing, a cardiologist in Mobile, Ala., who has received \$250 so far and expects to receive an additional \$750 from Biovail. “It’s worthless data. It takes less than five minutes for each patient, and an extra few minutes to explain to the patient that I want you to try this medicine and why”.....Dr. Massing said the money didn’t encourage him to prescribe more Cardizem LA. “I didn’t force them to pay me,” Dr. Massing says. “I would have used the drug [without the payments] but if they want to pay me \$1,000, that’s their choice. It won’t make me use the drug more or less” (Zuckerman 2003b).

Dr. Massing’s unwillingness to credit that his professional behavior might be affected by monetary compensation even as he admits that the “research” is useless from a methodological point of view is consistent with other conflict of interest

illustrations that will be presented. Massing's statement that "I didn't force them to pay me" recalls our consideration of "willful innocence" from Chapter Four. Although Cardizem LA is more expensive than generic versions of Cardizem CD and although there is no evidence of its advantage with prevention of heart attacks or strokes, there is no requirement that physicians in this program must disclose the compensation they are receiving to their patients (Zuckerman 2003b). Biovail had projected that 6,500 physicians would participate in this program which was said to be "winding down" after "higher-than-expected" participation (Zuckerman 2003b). Cardizem LA helped Biovail's shares to soar 60% in 2003 and is responsible for 7% of Biovail's overall sales of this perplexing<sup>296</sup> company that has a market value of more than \$6 billion (Zuckerman 2003b).

Literature from the United State estimates that \$8,000 to \$13,000 is spent annually on each physician (Wazana 2000: 373). With the lower value of the Canadian dollar, the estimate of \$20,000 (Canadian) "to educate" each physician in Canada seems congruent (Palmer 2003). Medical students and physicians seem to demonstrate a curious faith in their own Teflon-like abilities to shed any drug industry bias. While 85% of the medical students in one study believed it to be improper for politicians to accept a gift, only 46% found it improper for themselves to accept a gift of similar value from a pharmaceutical company (Palmisano and Edelstein 1980). In a study of medical residents, 61% stated that industry promotions and contacts did not affect their prescribing, but only 16% believed other physicians were similarly unaffected (Steinman, Shlipak, and McPhee 2001). The more money and promotional items that a physician-in-training received, the more likely that she or he tended to believe that discussions with drug representatives did not affect prescribing (Hodges 1995). While studies of attitudes of physicians toward pharmaceutical promotions demonstrate skepticism as well as unconcern, there is evidence that pharmaceutical industry promotions increase prescription rates for the

sponsor's product, non-rational prescribing, changes in prescribing habits, and requests by physicians to have drugs added to the hospital formulary (Wazana 2000).

Product information and treatment guidelines serve the dual purpose of reassuring the general public while creating a normative, technical decision tree matrix for clinicians. While many clinicians look to clinical practice guidelines as definitive references within complex, rapidly evolving fields, 87% of authors of clinical practice guidelines had some form of interaction with the pharmaceutical industry—58% received financial support to perform research and 38% served as employees or consultants (Choudhry, Stelfox, and Detsky 2002: 612). Only 7% believed that their own relationships with the industry influenced the treatment guidelines while 19% believed that their co-authors' recommendations were influenced by the pharmaceutical industry (Choudhry, Stelfox, and Detsky 2002: 614). In the published versions of 42 out of 44 clinical practice guidelines there was no disclosure of authors' potential conflict of interest (Choudhry, Stelfox, and Detsky 2002: 614). A "trick of the trade" advocated by *Pharmaceutical Marketing* is the advisory process as "one of the most powerful means of getting close to people and influencing them" (Moynihan 2003b: 1190). Less subtly, the American Heart Association accepted \$11 million dollars in contributions from Genentech while at the same time it was producing clinical guidelines about thrombolytics in strokes. Genentech is a U.S. producer of one such thrombolytic, which was recommended for stroke management by the American Heart Association (Lancet Editorial 2002).

Ray Moynihan (2003b: 1190) makes a compelling case that the "forms of entanglement" between physicians and the global pharmaceutical industry are multiple<sup>297</sup> and include what critics have called "checkbook science" as introduced in Chapter Four (Zuckerman 2003a). *PR Watch* cautions that when there is a public relations crisis, drug companies turn to "third-party partners."<sup>298</sup> Maxine Taylor,

Director of Corporate Affairs at Lilly UK, explains that third parties should be called upon “to share the spotlight if possible, or indeed to divert the spotlight of media attention from you” (Burton and Rowell 2003: 6). When the National Institutes of Health announced in July 2002 that they were cutting short their study of Prempro, Wyeth’s hormone replacement that had 70% market share, due to risk of increased health risks, Wyeth’s share price plummeted and lawsuits were filed. The Society for Women’s Health Research<sup>299</sup> condemned the NIH decision and distributed op-eds pieces and letters to newspapers nationally. Funding for this group is obscure as “our attorney says it is confidential information that we don’t distribute” (Burton and Rowell 2003: 6). Wyeth is a member of the Society for Women’s Health Research “Corporate Advisory Council” as are forty other corporations including Bristol Myers Squibb, GlaxoSmithKline, Merck, and Pfizer. “Health, Medicine & Research Partners” include the American Pharmaceutical Society as well as various professional organizations such as the American Medical Association. The Board of Directors is chaired by a Harvard Medical School Professor, Denise Faustman, MD, PhD, and is composed of eighteen members including Marcia Silverman, CEO of Ogilvy Public Relations Worldwide.

Wyeth-Ayerst commissioned ghostwriters to write ten articles promoting the diet drug fen-phen (fenfluramine, dexfenfluramine, and phentermine) as a treatment for obesity. Two of these were published in peer-review journals under the names of prominent researchers before the drug was withdrawn from the market for its links to heart valve damage and lung disease. Wyeth-Ayerst paid Excerpta Media, Inc. \$20,000 for each article. Excerpta’s ghostwriters produced first drafts, which Wyeth-Ayerst edited to delete descriptions of side effects. Excerpta then paid honoraria of \$1,000 to \$1,500 to well-known university researchers to edit the drafts. Described as “naïve,” the university researchers were not informed that their honorarium came originally from Wyeth-Ayerst (Rampton and Stauber 2001: 200-201). Rampton and Stauber argue that

this Wyeth-Ayerst example is “not an aberration” but illustrates a common public relations promotional practice of “flack doctors” writing articles or freelancer writers writing under a doctor’s name (Rampton and Stauber 2001: 201).

This topic has been spotlighted by the British mass media in the last two years. *The Guardian* reported that ghostwriting “has become widespread” especially in cardiology and psychiatry “where drugs play a major role in treatment.” With “eminent scientists” affixing their names to publications without having reviewed the raw data and lucrative fees being accepted for symposium talks, Fuller Torrey remarked, “Some of us believe that the present system is approaching a high-class form of professional prostitution” (Boseley 2002). *The Observer* quotes Dr. Richard Smith, editor of the *British Medical Journal*: “We are being hoodwinked by the drug companies. The articles come in with the doctors’ names on them and we often find some of them have little or no idea about what they have written” (Barnett 2003). Dr. David Healy of the University of Wales was offered a 12-page review paper to affix his name to by a drug company’s representative but his revisions were rejected for missing some “commercially important” points. This identical article then appeared at another conference and in another psychiatric journal under a different physician’s name:

Healy says such deception is becoming more frequent. “I believe 50 per cent of articles on drugs in the major medical journals are not written in a way that the average person would expect them to be...the evidence I have seen would suggest there are grounds to think a significant proportion of the articles in journals such as the *New England Journal of Medicine*, the *British Medical Journal* and the *Lancet* may be written with help from medical writing agencies,” he said. “They are no more than infomercials paid by drug firms” (Barnett 2003)

Even for articles that are not ghostwritten, it is difficult for readers to judge the objectivity of the findings in that authors often fail to disclose conflict of interest that might bias their findings. A 1996 study by Sheldon Rimsky investigated industry connection of 789 scientific papers published by 1,105 researchers in 14 leading

biomedical and science journals. In 34% of the papers, at least one of the chief authors had an undisclosed financial interest connected to the research. In 1999 a larger study by Rinsky examined 62,000 articles in 210 scientific journals and found only one half of one percent of the articles included information about authors' research-related financial ties (Rampton and Stauber 2001: 203-204).

Despite searching questions—"Is Academic Medicine for Sale?" in the *New England Journal of Medicine* (Angell 2000) and "Just How Tainted Has Medicine Become?" in *The Lancet*, plaintive editorials in the *British Medical Journal* (Abbasi and Smith 2003), and an activist "no-free-lunch" campaign<sup>300</sup> on the Internet, nondisclosure of potential conflicts of interest remains a significant challenge in biomedical journals. *Nature* and its sister publications are in the process of tightening their rules for disclosure of financial ties after a controversy concerning Dr. Charles Nemeroff, chair of psychiatry at the Emory School of Medicine (Petersen 2003b). Nemeroff did not disclose that he holds the patent on a lithium patch that he described favorably in an article where he evaluated two dozen new therapies. He also did not mention that he owns 60,000 shares of Corcept stock, which developed mifepristone, another drug whose effectiveness he highlighted. A third drug that he praised, milnacipran, is manufactured by Cypress Bioscience. Nemeroff is a Cypress board member, received \$36,000 in consulting fees in 2002, and had an agreement that he would receive \$100,000 "if he helped Cypress succeed"—none of which was disclosed (Petersen 2003c). Dr. Nemeroff said that "he has always been forthcoming" about his financial relationships and pointed out that in a recent case he had disclosed that he was a consultant to 20 pharmaceutical companies including Pfizer, GlaxoSmithKline, Eli Lilly, Merck and Forest Laboratories (Petersen 2003b).

The extent to which corporate sponsorship is threatening to infuse arenas previously dominated by governments and universities may be seen in a November



2003 controversy within and about the Cochrane Collection. This international network of 10,000 researchers evaluates data on the value of therapies from acupuncture to zinc supplements has been described as “the most visible manifestation of the ‘evidence-based medicine’ movement” (eCMAJ: 1). The Cochrane Collection has a policy discouraging industry sponsorship from companies with a vested interest in the outcome of a review, “but the policy is increasingly ignored as some within the organisation argue that industry money is crucial to their survival” (Moynihan 2003a: 1005). At a 10<sup>th</sup> anniversary meeting of the Cochrane Collaboration in Barcelona that was sponsored by several pharmaceutical companies, a variety of viewpoints were elucidated. Cindy Mulrow, deputy editor of the *Annals of Internal Medicine* proposed “a mechanism for accepting that would limit amounts from particular sources, direct funds to general accounts, and ensure that those who dispersed the money did not know its source” (Moynihan 2003a: 1005). Joaquim Camprubi from Merck said “financial ties between researchers and industry should be considered in a positive rather than a negative light” (Moynihan 2003a: 1005). Peter Gotzsche, director of the Nordic Cochrane Center, argued that drug company sponsorship would corrupt systemic reviews. Evidence cited to support this view was given by Vasiliy Vlassov who described a drug company seeking to sponsor a review of its product, so long as the review was favorable. Martin Offringa of the Dutch Cochrane Center gave examples of drug companies offering funds for reviews in order “to make their products look ‘evidence based’ for marketing purposes” (Moynihan 2003a: 1005). The seductive lure of industry funding and its resulting ambivalence for some individual researchers may perhaps be illustrated by the following:

Dr. Gordon Guyatt of McMaster University, a key architect in the move toward evidence-based medicine, recently helped produce a series of Cochrane reviews on osteoporosis. They were partially funded by a US \$150,000 grant from Merck Sharpe & Dohme, which markets a drug to reduce fractures. Guyatt is now ambivalent about drug company

sponsorship: "Having had this positive experience, I've lost my objectivity," he says (eCMAJ: 2).

Eyal Press and Jennifer Washburn have described the dynamics of universities abandoning the quest for "disinterested inquiry" as they behave increasingly like for-profit corporations as "the kept university" and the "academic industrial complex" (2000). As states struggling with their budgets reduce funding for higher education (Uchitelle 2003), there is increased pressure for institutions and researchers to "become eager co-capitalists, embracing market values as never before" (Press and Washburn 2000). An estimated 60% of biomedical research in the United States is privately funded and two thirds of academic institutions have equity ties with outside sponsors (Moynihan 2003b: 1189). Canadian universities and hospitals received \$161 million from industry in 2000, which was more than the amount from provincial governments combined and half the amount received from federal sources (Lewis et al. 2001). Lewis et al. argue that "drug companies have a fiduciary duty to exploit the intellectual talent and ethical credibility of universities to advance their interests" (2001: 783). Warning universities against "interests that align with those of their paymasters," Lewis et al. use "dancing with porcupines" as their cautionary metaphor.

The fiduciary duty of the pharmaceutical industry to its investors may conflict with ethical norms designed to protect patients and scientific standards of transparency ensuring rigor. A 540-page report by the Canadian Association of University Teachers details the case of Dr. Nancy Olivieri, a specialist in hereditary blood diseases affiliated with the Hospital for Sick Children and the University of Toronto. In 1996 Olivieri identified an unexpected medical risk during a clinical trial of a drug sponsored by Apotex. The company disputed the risk and the need to inform patients of the risk to the extent that Apotex threatened Olivieri with legal consequences should she disclose this information. The University of Toronto's Dean of Medicine mediated between Apotex

and Dr. Olivieri whereby patients who were benefiting from Apotex's treatment could continue taking it with full disclosure and monitoring. In 1997 Olivieri identified a second, more serious risk associated with Apotex's drug, which Olivieri reported to regulatory authorities as she weaned her patients off the drug under investigation despite further legal warnings by Apotex. This is a complicated narrative of investigations, lawsuits and countersuits as well as egregious behavior by her colleague, Dr. Gideon Korten, who was disciplined for gross misconduct for sending anonymous letters disparaging the personal and professional integrity of Dr. Olivieri.

For the purposes of this discussion it is sufficient to point out that in the midst of corporate behavior that threatened the public interest, Dr. Olivieri was not supported by the Hospital for Sick Children or the University of Toronto in the "exercise of her rights and obligations" as a medical researcher (Thompson, Baird, and Downie 2001: 14). The University of Toronto was engaged with discussions with Apotex about a major donation (\$20 million to the University of Toronto and \$10 million to the University for the affiliated teaching hospitals) throughout the 1990s. In 1999, as this controversy with Olivieri was going on, the President of the University of Toronto, at Apotex's request, wrote to the Prime Minister of Canada to urge delaying action on proposed changes to drug patent regulations that would adversely affect Apotex's business (Thompson, Baird, and Downie 2001: 23). This led to the recommendation by the Canadian Association of University Teachers that hospitals affiliated with universities as well as all universities "should have policies on development to ensure that fund-raising possibilities do not have an adverse impact upon the institution's willingness or ability to protect and promote academic freedom and the public interest" (Thompson, Baird, and Downie 2001: 19).

This is not an isolated example of the pharmaceutical industry using a carrot of donations or the stick of legal action for their own ends. The Center for Addictions and

Mental Health in Toronto withdrew its offer of employment to Dr. David Healy after he gave a speech that was critical of Prozac. Eli Lilly, manufacturer of Prozac, donated \$1.55 million to the Center for Addictions and Mental Health in 2000. Eli Lilly withdrew its corporate funding of the Hastings Center after its journal published a series of articles that were critical of prescribing practices for antidepressants. Bristol-Myers Squibb initiated a lawsuit against the Canadian Coordinating Office on Health Technology Assessment to suppress its statin report and AstraZeneca threatened legal action against McMaster University researcher Anne Holbrook for her review of medications on stomach disorders (Lewis et al. 2001: 784).

Even without such direct pressure, there is evidence that drug industry sponsored research tends to be more supportive of the therapy being examined than research conducted by independent reviewers (Friedberg et al. 1999) (Stelfox et al. 1998). Lewis et al point out that the industry does not have to depend on “high-risk and brazen strategies” such as falsification of data; “it is achievable by framing the questions and the design of studies to increase the probability of a positive result” (2001: 784). In fact, a number of research experiments that have resulted in harm to research subjects underscore conflict of interest problems that run along several fault lines. As many as twenty research participants may have died unnecessarily during the course of a twelve year long cancer treatment study at the Fred Hutchinson Cancer Center in Seattle in the 1980’s and 1990’s. An investigatory report by the *Seattle Times* suggested that financial interest in Genetic Systems by the investigators and the Fred Hutchinson Cancer Center might have colored their scientific judgment (Beh 2002: 28). Another fault line in this complicated account is that the lead researcher chastised the institutional review board responsible for reviewing their protocols by stating that they were “required to assist the researchers and not hinder the research” (Beh 2002: 29). Substantial conflict of interest may also be pertinent in the death of eighteen-year old Jesse Gelsinger who died after

infusion of a genetically altered virus in 1999. Gelsinger and his family were misled by the researchers: “there was virtually no chance that the experiment—which researchers insisted on calling a *therapy* trial—would provide him with any therapeutic benefit” (Beh 2002: 30). A lawsuit filed against the University of Pennsylvania by Gelsinger’s estate alleged that the researchers concealed prior adverse events, failed to obtain informed consent, and failed to disclose that both the institution and the director of the gene therapy institute would profit from the discovery because both had a financial interest in the company that sponsored the gene research (Beh 2002: 31).

Given the potential for systemic bias not adequately addressed by institutional review boards, it is problematic that the National Institutes of Health are advocating “a new vision for biomedical research” that would “transform the way we conduct research” by fostering “greater collaboration between the government and private industry” (Pear 2003a). Critics worry that promises of “we are turbocharging the NIH” to “reduce the burden on researchers” are occurring while some arenas of research such as gene therapy are already inadequately regulated and supervised. Additional concerns expressed by some members of Congress are that corporations reap huge profits from drugs such as Taxol were developed with public money without the government receiving adequate royalties for its investment just as high drug prices leave medicines unaffordable for many patients (Pear 2003a).

In December of 2003 it was revealed by the *Los Angeles Times* that “more than 94% of the NIH’s top-paid employees were not required to publicly disclose consulting income” from biomedical companies (Willman 2003b). Representative James Greenwood (R-Pa), chair of the House Oversight and Investigations Committee, said that more than just being a “revolving door” between industry and the federal government, “this is a swivel chair” (Willman 2003b). Dr. Ronald Germain, deputy director of the NIH’s Laboratory of Immunology, for example, has an annual

government salary of \$179,900 but made more than \$1.4 million in consulting fees<sup>301</sup> and gathered company stock options valued at \$865,000 over the last 11 years (Willman 2003a). A blue-ribbon advisory panel that was convened by the NIH to advise on self-regulation was described in May 2004 as “an apology for the status quo”<sup>302</sup> (Willman 2004). Representative Peter Deutsch (D-Fla) continued his analysis by saying that former and current NIH leaders “had encouraged the option of corruption” (Willman 2004). Pertinent to ongoing discussions within this dissertation of willful ignorance in the context of market fundamentalism, it is also salient that Representative Joe Barton (R-Texas) Barton described “the attitude often found at NIH: ‘The rules don’t apply to us.’ Now, I sense we are hearing a variation on this theme: ‘If the rules do apply to us, they shouldn’t’” (Willman 2004).

Reiterative Drug Discourse: Different Grandparents, Old Problems, Same Dynamics

**St. Petersburg, Florida, 1959:**

Economist John Blair talked with a retired railroad man who “told me that he had rheumatoid arthritis, and that he had to take three or four pills a day of Deltasone, Upjohn’s brand of prednisone, which, like the other versions sold under trade names, retailed for thirty cents a pill. His income amounted to four dollars a day, and he spent an average of a dollar a day on Deltasone. On top of that, his wife was diabetic and had to take three Orinase tablets a day, which ran to over forty cents. The old fellow said that at the end of every month he had to give up his medicine for a couple of days so that he could afford to buy his wife’s. His medicine only eased his pain, but hers kept her alive...Of course, most of them live on marginal incomes, which means that toward the end of the month they have to cut down on their drugs or their food, and when it’s a matter of choosing between pain and hunger, they seem to choose the hunger” (Harris 1964: 36-37).

**Seattle, Washington, 2003:**

“I see people who can’t eat every day because they have to buy their medications,” said Cathy Lobdell, a retired credit manager who coaches other senior citizens how to buy Canadian drugs by phone or via the Internet. “My own medicine would be \$500 a month if I didn’t get it from Canada for 50 percent less,” said the 76-year-old, whose regular drugs include several Glaxo inhalers. “It’s just total greed by the drug companies and our own government isn’t doing squat for us” (Doughton 2003).

Students of the political theatre leading up to President Bush signing the Medicare reform bill with a prescription drug component on December 8, 2003 and/or those who have been monitoring the on-going drama of individuals and local and state governments illegally purchasing medicine from Canadian suppliers and/or those who were entranced by the rhetoric of the joint hearing on the Comprehensive Child Immunization Act of 1993 all might experience a frisson of déjà vu reading Richard Harris’s account of Senator Estes Kefauver’s investigation of the drug industry by the Senate Subcommittee on Antitrust and Monopoly. Excessive profits,<sup>303</sup> price fixing,<sup>304</sup> disproportionate cost of medicine purchased in the United States compared with other countries,<sup>305</sup> unethical marketing practices,<sup>306</sup> complicity of organized medicine with the

pharmaceutical industry,<sup>307</sup> public relations campaigns, and torturous back-room political deals<sup>308</sup> were features of the investigatory landscape from 1958 until Public Law 87-781 was signed by President John Kennedy on October 10, 1962 (Harris 1964: 245). After extensive hearings on the pharmaceutical industry the three main goals for legislative action that Senator Kefauver identified by 1960 were to lower drug prices, increase competition so that small manufacturers would get a fair share of the market, and a way “to assure the *emptor* that he needn’t *caveat* every time he had a prescription to be filled” (Harris 1964: 119).

Kefauver’s investigation that revealed the use of public relations firms to plant articles on the wonders of their clients’ products in lay magazines, although direct to consumer advertising was not sanctioned at the time, may not be surprising to the reader of 2004 used to direct-to-consumer advertising. As with the defenders of direct-to-consumer advertising today,<sup>309</sup> the most specialized public relations agency of 1962, the Medical & Pharmaceutical Information Bureau, cast its work as a public good. Its head, John Weilburg, testified:

“In a modest way, the Medical & Pharmaceutical Information Bureau speeds up the process of satisfying the public need for valid information on health and medical subjects,” he said, and added, “For ourselves, we take pride in the part we have played in helping to report significant advances in medical science to the public” (Harris 1964: 129).

The Medical & Pharmaceutical Information Bureau’s “Spotlight on Health” promotional copy syndicated as “news” to the editors of two thousand small newspapers across the country (Harris 1964: 130) was a precursor of today’s “video news releases” that feature “entire news stories, written, filmed, and produced by PR firms and transmitted by satellite feed or the Internet to thousands of TV stations around the world” (Rampton and Stauber 2001: 23). “Blurring the line between journalism and advertising” is accelerated by the use well-respected journalists<sup>310</sup> and “well-spoken doctors who have been coached so that their delivery perfectly fits the format of a news program, and the



VNRs rarely mention that the doctors have been hired by the drug suppliers to test and promote their products” (Rampton and Stauber 2001: 24).

In response to the Kefauver investigation “the industry prepared for war” (Harris 1964: 47). Although this illustration could be explored from many different perspectives, three reoccurring refrains used in the middle of the 20<sup>th</sup> century carry forward to the 21<sup>st</sup> century are pertinent for this narrative. The first is that perceived miracles attributed to biochemistry are powerful symbols difficult to dislodge in favor of more nuanced discourse. One strategy to refocus attention away from a discussion of what might be a reasonable price for a drug is to highlight other factors that are portrayed as distinct from the particular market relationship under examination. Francis Brown of Schering Corporation argued:

The basic issue was not the price of drugs, Brown felt, but, rather, he said, “It is a matter of inadequate income,” and suggested that Congress study *that* problem. Then, coming back to steroids, he concluded, “Men walking who were crippled, and working who were incapacitated, at a cost of between thirty and sixty cents a day, seems to me to be pretty reasonable” (Harris 1964: 56).

The partner trope to “it is not for the profits” and “price is not the issue” is the assertion that “it is for good of the patient.” Raising the dead and making the lame walk is always more captivating than complicated and difficult considerations of why people need miracles in the first place. Dr. Austin Smith, president of the Pharmaceutical Manufacturers Associated asked Senator Kefauver for two favors shortly after the hearings were announced. The first was

that the subcommittee use only generic names during the hearings, so that the delicate doctor-patient relationship would not be upset—in other words, that patients would not acquire undue knowledge about what was being prescribed—and that he himself be called as the first witness (Harris 1964: 46).

Kefauver was heavily criticized for not granting either request but for our purposes it is sufficient to note the logic of Dr. Smith’s requests for primacy and non-disclosure of

pertinent information under the guise of potential hazard to the “delicate doctor-patient relationship.” A correlative framing to presenting the biomedical industrial nexus as the hegemonic, beneficent perspective is the allegation that critics of biomedical market interests are self-servingly motivated which is often framed as being “political.” *Drug Trade*, for example, denounced Kefauver’s decision to go ahead with investigations into the drug industry as “politically inspired” (Harris 1964: 47) . Substantive discussions of the implications of the Medicare reform bill of 2003 were derailed by media accounts willing to settle for assertions that “it’s almost impossible here to tease out the difference between policy and politics” (Edwards 2003b). The framing here is that the primordial politics involves “Republicans basically trying to steal a Democratic issue” (Siegel 2003a) thereby delegitimizing scrutiny of the details of proposed reform.

The last familiar image that was rhetorically harnessed was the specter of socialism. The pharmaceutical industry financed Senator Estes Kefauver’s political opponent, Judge Andrew Taylor, during the 1960 campaign. This support included eighty thousand pieces of literature sent out by physicians and druggists with their bills “which described Kefauver as a Socialist hellbent on ruining the health of the American people” (Harris 1964: 116). One of Kefauver’s staff members, Paul Rand Dixon, a former Federal Trade Commission lawyer, described the response against Kefauver as follows:

“In taking on the drug industry, he also inevitably took on not only such organized groups as the AMA, chambers of commerce, and druggists’ and businessmen’s associations but a good many backward doctors as well. These drug fellows pay for a lobby that makes the steel boys look like popcorn vendors. In the end, they mounted against Estes the most intense attack that I’ve seen in a quarter of a century in Washington. Anybody who dares seek the truth will be accused of being a persecutor. Estes was certainly accused of that, and much more. Before the hearings were over, he was even accused of spouting Socialism. We never had any intention of questioning anyone’s right to make as much money as his ingenuity would allow. All we wanted to do was compare this industry with others in order to see whether there was any monopoly, and, if so, what should be done about it. Hell, all Estes ever did to rile those fellows was the raise the ugly head of free enterprise” (Harris 1964: 47).

If Dixon is correct in his assessment, it is important to note that the underlying objection of Kefauver's critics is not against ideal "free enterprise" or perfect "free trade" but resistance to any form of market activity that does not privilege their parochial interests.<sup>311</sup>

In April 1993 the Secretary for the Department of Health and Human Services, Donna Shalala, presented data from the Centers for Diseases Control and Prevention that 40 to 60 percent of children at two years of age in the United States were not fully immunized. In some inner cities, the rate for toddlers was as low as 10 percent. Failure to immunize led to a resurgence of measles between 1989 and 1991 that resulted in 55,000 cases of measles, 130 deaths, and 11,000 hospitalizations with an estimated \$150 million cost in direct medical costs (*Comprehensive Child Immunization Act of 1993*: 40). Representative Louise McIntosh Slaughter's opening statement included the information that between 1981 and 1991, the price of a single dose of DPT rose from 33 cents to \$10, an almost 3,000 percent increase. Supporting expense as a significant barrier to improved immunization rates, Slaughter pointed out that costs ranged from \$250 to \$500 per year for families to vaccinate one child. Slaughter urged "politics and profit margins aside, the young children of America must be our only concern" (*Comprehensive Child Immunization Act of 1993*: 11). The underlying premise of this Clinton plan, which included the provision for the federal government to purchase vaccines at a negotiated price to be given at no cost to providers, was explained by Shalala:

Proper immunization should be a basic right for every child in America, rich or poor, just like in most industrialized countries. We don't "means test" the right to public education, we don't "means test" the right to clean air or clean water. Nor should we make access to the most basic form of disease prevention a matter of family income (*Comprehensive Child Immunization Act of 1993*: 42)

In contrast to the argument that health, or at least preventative health care, is a human right, testimony was presented that health care is just another commodity to be purchased as any other. In his opening statement, Senator Judd Gregg argued:

In fact, I think it is a legitimate request to ask the parents of moderate income to pay \$400 to \$500 over a 2-year period for immunization —probably significantly less than they pay in car payments or maybe even for their cable television costs. The moderate-income individuals should invest in their children’s health care, and the government has no obligation to pick up that cost. If the parents are going to pay for their cable TV, they can pay for their children’s immunization (*Comprehensive Child Immunization Act of 1993*: 15).

Using the rhetoric of individualism imbedded within liberalism, Gregg identified “the problem” as singular and as “parents don’t take responsibility to have their kids immunized” (*Comprehensive Child Immunization Act of 1993*: 14). Gregg warns that the program under consideration “would eventually lead to the nationalization of the immunization drug programs in this country” (*Comprehensive Child Immunization Act of 1993*: 14). Representative Scott Klug also cautioned against “nationalizing this country’s vaccine business” and then recycled anti-Russian rhetoric familiar from organized medicine assaults against “socialized medicine” discussed in Chapter Three:

We have pockets of hunger in this country, but we don’t nationalize the bread industry, and we have a shortage of apartments in some cities, but we don’t nationalize the housing industry. If nationalization were the key to success, it would be the Russian Parliament working on a foreign aid package to the United States (*Comprehensive Child Immunization Act of 1993*: 32).

Senator John Danforth argued that “the problem is not cost” but reasons for lack of immunizations include complexity of informed consent forms, transportation problems, parents’ and doctors’ lack of knowledge, inaccessible hours of public health clinics, and unsatisfactory reimbursement rates to physicians that are lower than the cost of buying the vaccines (*Comprehensive Child Immunization Act of 1993*: 37-38). The heart of Danforth’s argument is “a universal purchase program to totally disrupt the market system is one which attacks a very basic economic premise in this country which has

worked very well with respect to developing and bringing into the marketplace new products" (*Comprehensive Child Immunization Act of 1993*: 38).

Perhaps not surprisingly, representatives of the pharmaceutical industry<sup>312</sup> framed their resistance to universal purchasing by linking it to capacity to do innovative research rather than profit. Consider this exchange between Representative Henry Waxman and Dr. Ronald Saldarini, president and chief executive officer of Lederle-Praxis Biologicals:

Waxman: ...you don't like the idea the idea of the government buying all the vaccines from you because you are afraid you are going to get less money. Is that an accurate statement?

Saldarini: It's not entirely accurate in the way you put it. We are going to have less flexibility, I think, we feel, in terms of making decisions about research, research projects, vaccine projects and so forth (*Comprehensive Child Immunization Act of 1993*: 156)

It is fascinating to read the transcript of exchanges between members of Congress and the pharmaceutical industry for their obvious unwillingness to engage in a discussion about a rationale for lower drug prices in Canada compared with the United States.

Consider this exchange between Senator Riegle and Jean-Pierre Garnier of SmithKline Beecham:

Riegle: ...I mean, why should we concede to you a higher profit when the country living right next door has figured out how to get you to sell them exactly the same vaccine at a lower price? Why should we spend money we didn't need to spend that they aren't spending, so you can have more profit? Is that fair?

Garnier: No, but let me try to address the question. The reason we are uncomfortable having a discussion like this obviously is because the criteria upon which governments negotiate with us the price of vaccines vary enormously, so it is very difficult to answer your question because we are not comfortable with the process that is being used in Canada and the U.K. and so forth (*Comprehensive Child Immunization Act of 1993*: 160-161)

Ten years later the same Jean-Pierre Garnier of GlaxoSmithKline has moved from discomfort to a blatant assertion in the context of an interview for *Health Affairs*:

In some countries the government intervenes to pick our pockets, to put it bluntly. And that's unfortunate, because it creates distortions. Suddenly,

the American consumer is subsidizing a little bit more research than maybe his or her European counterpart does. That's also true for defense, but nevertheless, I wish it weren't the case. I wish there were free pricing, because then we would arrive at a weighted average, which would be probably a touch lower in the United States, and certainly a lot higher in Europe and in Canada (Iglehart 2003).

Over a decade of practice fielding questions about price differentials, the consummate public relations spin is to divert attention from a discussion of whether the pharmaceutical industry is being "fair" in its pricing and profit margins to blaming Europeans and Canadians for not paying a "fair" price for the product. "Free pricing" as code for charging exactly what the industry wants is also a strategic phrase that reinforces market norms. Garnier's skillful rhetorical diversion that obscures whose pocket is being picked is worthy of one lifting wallets as a profession. Even so, this mantra of Canadians getting "a free ride off the U.S. system" is a major public relations talking point in news releases put out in the fall of 2003 by American<sup>313</sup> and Canadian<sup>314</sup> conservative think tanks advocating market solutions to the prescription drug policy debates.

A variety of physicians<sup>315</sup> testified at this joint hearing on behalf of state and county health departments, the Association of State and Territorial Health Officers, and the American Academy of Pediatrics. As with the physicians who testified as officers of their pharmaceutical companies, their stances seemed to be fairly congruent with the mission of their respective organizations. Linking back to the previous discussion of "third party experts" advocated by the public relations industry, Dr. Richard Duma's testimony as executive director of the National Foundation for Infectious Diseases might be seen as disingenuous. Dr. Duma's testimony reiterated that vaccine cost is not the problem but instead improvements need to be made in "education, attitudes, delivery, and tracking" (*Comprehensive Child Immunization Act of 1993*: 177). Duma warns:

Finally, just when the science of immunology and vaccines are at the threshold of great discoveries, and just when many new promising

biotech companies are entering the arena of vaccinology, the notion of government control over vaccines threatens to stifle their involvement and their new developments. The bright people these contain, as well as the venture capitalists that support them, may soon be departing (*Comprehensive Child Immunization Act of 1993*: 180).

Duma started his testimony by identifying himself as an infectious diseases specialist and described the National Foundation for Infectious Diseases as “a non-profit public foundation” (*Comprehensive Child Immunization Act of 1993*: 176). What Duma did not disclose until questioned by Senator Riegle was the extent to which his foundation was financially supported by the pharmaceutical industry:

Riegle: Can you tell what percentage of the foundation’s endowment and operating funds come directly or indirectly from contributors in the pharmaceutical industry?

Duma: It would probably be in the area of maybe 30 percent, something in that order.

Riegle: It wouldn’t be higher than 30 percent?

Duma: It might be. I can’t give you the exact figure right now, but it is less than 50 percent (*Comprehensive Child Immunization Act of 1993*: 182).

Senator Riegle’s questions were prompted by the degree to which Duma’s testimony on cost echoed that of the pharmaceutical industry. Other physicians, such as Ed Marcuse of the American Academy of Pediatrics, identified a number of disincentives to satisfactory immunization rates, but out-of-pocket expenses for families headed his list (*Comprehensive Child Immunization Act of 1993*: 165). The point here is that Duma’s bias in favor of the “bright people” and “venture capitalists” that privilege research and industry was cloaked by his professional credentials as an infectious diseases physician directing a “nonprofit public foundation.”

“I think it is important, though, to buy within a system where you’re not on your own, where you’re not in the Wild West.” Mark McClellan, MD, PhD, Commissioner of the Food and Drug Administration<sup>316</sup>

Dr. McClellan’s use of the “Wild West” metaphor<sup>317</sup> on September 12, 2003 extended the outlaw theme of his Willie Sutton imagery on September 4, 2003 (“If Willie Sutton were alive today he would be counterfeiting Viagra because that’s where the

money is”) as part of the Food and Drug Administration’s campaign against importing prescription drugs from Canada into the United States. In a letter written by McClellan read on the Senate floor, he said the “FDA cannot guarantee the safety of Canadian drugs” (Fresno Bee 2003). The pharmaceutical trade group, Pharmaceutical Research and Manufacturers of America (PhRMA)<sup>318</sup> claimed that any bill “to legalize reimportation of drugs from Canada would invite the probability that many such drugs will be unapproved, adulterated, contaminated, or counterfeit” (Olive 2003a). Raising the stakes even higher, Senator Thad Cochran said that “bringing prescription drugs into the United States opens a new door, a new opportunity for bioterror” (Fresno Bee 2003). As an economist and a physician, McClellan was able to package the double threat of danger from terrorism and unsafe drugs by underscoring how his agency lacks resources. “We’re against large new gaps in the nation’s ability to protect its citizens from potentially unsafe drugs, at a time when the threats to safety of our drug supply are greater than ever” (Connolly 2003).

It is fascinating to note the recent preoccupation of the Food and Drug Administration with “counterfeit” drugs just as more states and cities are turning to imports that are 20%-80% cheaper (CBC News 2003). McClellan agreed with and then later tried to distance himself from a journalist who characterized Canada’s drug policies as “parasitic” because “they’re living off of the research that we do” (Whitwham 2003). The Food and Drug Administration<sup>319</sup> was so actively engaged in “educating lawmakers,” which is often code for lobbying,<sup>320</sup> against a bill to allow drug imports that Representative Sherrod Brown observed “The call we got from the F.D.A. illustrates the way the pharmaceutical industry has co-opted the Food and Drug Administration” (Stolberg 2003). While the Food and Drug Administration argued “most imported drugs are counterfeit knockoffs that could seriously endanger the health of those taking them,” Representative Gil Gutknecht accused the FDA of “paying politics with the inspections.”



Gutknecht complained “The F.D.A.’s blind refutation of fact and its duplicity in making safety claims are predictable and pathetic” (Harris 2003e).

Perhaps more to the point is Majority Leader, Tom Delay’s characterization of drug imports as “horrible policy”—“from a free-market perspective, I’m not interested in importing price controls” (Stolberg 2003). Pfizer would certainly agree with this perspective from their actions designed to protect their profits while undercutting the safety argument. Pfizer sent letters to 50 pharmacies that they believe might be exporting drugs to the United States informing them that they must order their drugs directly from Pfizer rather than from wholesalers. Pfizer, along with GlaxoSmithKline, AstraZeneca, and Wyeth, intend to curtail shipments of drugs that they deem to exceed Canadian demand in order to respond to cross-border prescription sales of \$650 million per year (Harris 2003h). This could ultimately be a more effective way of limiting prescription drug imports than legislation because the drug industry keeps “close tabs on doctors’ prescriptions” so they can track demand and buying trends (Harris 2003h). By the end of October 2003 the chief executive of Pfizer, Henry McKinell was able to report to industry analysts that over a few months Pfizer<sup>321</sup> was able to reduce the amount of its drugs being imported from Canada into the United States to less than \$10 million per year from about \$40 million (Harris 2003d).<sup>322</sup>

Once again it should be noted this action is predictably framed as being in the best interests of patients and not for profits. A spokesperson for GlaxoSmithKline, Nancy Pekarok, explained that measures against Canadian exporters are “meant to ensure that drugs needed by Canadians were not diverted to the United States” (Harris 2003h). An Eli Lilly spokesperson, Rob Smith, said of limiting sales of its drugs to amounts that Lilly estimates are sufficient for the Canadian market, “We think it’s an appropriate step to take to protect the integrity of our products and the safety of our patients here in the U.S. and Canada” (Associated Press 2003a).

Behind the rhetoric of protecting patients and products, one gets to the crux of an industry protecting its profits. A report sponsored by Merck Frosst, publicized in Montreal where Merck has facilities, made clear that “pharmaceutical companies won’t tolerate the current trend toward Americans buying cheaper Canadian drugs” (Thompson 2003). In this report Marcel Cote<sup>323</sup> says “It is clear that for its own benefits, the onus is on Canada to stop grey-market sales to the U.S. Otherwise, the likelihood is for higher prices in Canada.” To this stick, Cote added a carrot that recycles us back to the theme of intellectual labor and intellectual property rights:

In fact, Canada accounts for 2 per cent of the global consumption of prescription drugs, it receives only one per cent of the global research and development budget for life sciences, he said. Currently, 70,000 Canadians are employed in the life sciences sector, half of them in research. That could change, Cote said, adding drug companies could increase their research and development spending in Canada by 50 per cent over 10 years if the conditions are right. Among measures Cote recommends are beefing up Canada’s intellectual property rules to make them competitive with those in Europe and the U.S. “There is no reason why Canada’s intellectual property rights regime for pharmaceuticals should be more or less liberal than those of our major trading partners” (Thompson 2003).

At one point as the industry was studying “whether it makes financial sense to stop selling to Canada,” a drug-industry official said, “Congress can’t make us sell to Canada” (Cusack and Stinson 2003). In addition to warnings about higher prices, lost employment, and prescription drug shortages, not having access to cutting edge treatments is a threat and reality that is of concern to clinicians and patients. One example is a drug called tenofovir which could be used with patients with HIV disease who are experiencing serious side-effects<sup>324</sup> with their current antiretroviral regimes. Gilead Sciences Inc. representatives told Canadian physicians at an International AIDS Conference in Paris in 2003 that tenofovir would not be marketed more widely in Canada because it might be exported back into the United States at lower prices. Infectious diseases specialist, Dr. Michael Silverman said:

"The representatives said, 'The problem could be fixed pretty quickly if you guys could fix that Internet pharmacy problem...Why would we sell it to a small market in Canada that might threaten our American market?'" he recalled. He quoted the representative as saying, "Everyone gets the same price or they don't get it" (Blackwell 2003a).

Dr. Silverman did not think the cross-border trade was "in the average Canadian's interest. It's short sighted and it's going to wreck a good thing." He asked, "Should we ruin our system to make a political point in the United States?" (Blackwell 2003a). One of Silverman's patients, Lynn Kampf, said that she was sympathetic to people seeking less expensive drugs from Canada but "feels Canada is being hurt as a result."

"They're holding people with diseases in Canada hostage," she said. "Why should Canadians be selling drugs back to the Americans? Let the Americans fight their own battles at home" (Blackwell 2003a).

While some individual physicians in Canada perceive writing scripts for American patients as an issue of social justice and/or a source of revenue,<sup>325</sup> organized medicine in Canada has gone on record as being against cross-border exportation of drugs. Dr. Sunil Patel, President of the Canadian Medical Association, testified to the House of Commons Standing Committee on Health:

The CMA shares the increasingly prevalent concern that cross-border export will result in reduced access to prescription drugs in Canada, and damage the research and development capacity of brand-name prescription drug manufacturing in Canada. Therefore the CMA recommends that Canada monitor and, if necessary, regulate the export of brand-name drugs to ensure their continued availability in this country (Patel 2003: 9).

Meanwhile in the United States President Bush described the new Medicare bill as "historic reform" that "will strengthen the system, that will modernize the system, that will provide high-quality care for the seniors who live in America" (Block 2003). In contrast, Senator Edward Kennedy "thinks it's a Trojan horse designed to kill Medicare" (Edwards 2003f). Kennedy asserts that:

(The) bill has been hijacked by the Republicans in the House of Representatives, and now what they are attempting to do is, under the guise of a prescription drug bill, privatize Medicare, do nothing about

the costs of Medicare, bring the, I believe, the beginning of the end of the Medicare system under the guise of a prescription drug program (Edwards 2003e).

While the specifics of this legislation could be the source for a different dissertation, there are several important points evident in this Medicare reform discourse that support assertions previously made. The first is that formal support of this legislation by organized medicine, if not all of its members, and the AARP (formerly called the American Association of Retired Persons) gave the bill credibility. The administrator for the Centers for Medicare and Medicaid Services, Thomas Scully, specifically said:

The American Hospital Association, the American Medical Association, the Catholic Health Association. If it wasn't a really good bill, these people wouldn't be supporting it (Edwards 2003f).

Before the Senate voted on the bill Senate Majority Leader Bill Frist read a long list of medical organizations that supported the bill that included the American Medical Association, the American Hospital Association, the Family Physicians, and the American College of Cardiology (Edwards 2003c). Julie Rovner noted that "putting the hospital and physician payment changes in the Medicare bill was no accident" (Edwards 2003c). Increasing Medicare payments to doctors<sup>326</sup> and giving hospitals a full inflation adjustment was a strategic decision to woo health provider support for "what promised to be a contentious bill." As Republican strategist and lobbyist Mark Isakowitz explained:

In most places of the country, the local doc is a respected person and the local hospital is a respected institution. And so getting those people mobilized, as they were, and writing and calling made a big difference. And it wasn't just a quantity of people lobbying for the bill, but it was the quality. It was respected members of your community saying, "I need this for the future health of my institution or my doctor's office" (Edwards 2003c).

A second striking observation that coincides with the legitimation of health policies by these "respected members of the community" is the extent to which conflicts

of interest are integral to this exercise in crafting public policy. In November 2003 medical organizations supported this prescription drug bill with its increase in Medicare provider payments. In August 2003 oncologists were lobbying against a proposal in the prescription drug bill for Medicare to pay doctors close to the actual cost of oncology medicines that they administer rather than continue the custom of letting them pocket the difference they receive on discounted medicines.<sup>327</sup>

Reimbursing physicians “fairly” for office visits (which includes the cost of intensive nursing care required for infusions that require close monitoring over eight hours) could come close to \$40,000 per year per doctor. Dr. Dean Gesme is an oncologist who warns that loss of income would threaten his support system of nurses, social workers, and billing clerks:

If we’re forced to cut, we’re going to break apart that system. A lot of patients will end up in the hospital. They’ll use the social worker, a psychologist there who really doesn’t understand cancer, doesn’t understand the drugs and technology, won’t know the sources to provide benefits to those people (Silberner 2003).

Only rigorous fidelity to market fundamentalism can possibly defend this as “a system of health care.” The opportunities to privilege private over public good are multiple where billing clerks play integral roles of support within systems for patients and their physicians.

The \$400 billion Medicare overhaul was described by health care industry analyst, Ira Loss, as having “something here for everybody...a classic election-year giveaway, a year early” (Abelson and Freudenheim 2003). In addition to increased Medicare payments to physicians, the dollar figures attached to this bill include \$20 billion in added payments for hospitals, roughly \$15 billion to private health plans to pursue them take on a larger role under Medicare, and \$70 billion or more to employers as subsidies to discourage them from dropping health coverage for their

retirees (Abelson and Freudenheim 2003). Alan Sager and Deborah Socolar<sup>328</sup> studied the impact that the Medicare reform legislation would have on the drug industry:

Drug makers' net increase in profit is estimated at \$139.2 billion over the eight-year early life of the program. This rise in drug makers' profit constitutes fully 61.1 percent of the \$228 billion in Medicare dollars used to buy additional prescription drugs for patients previously unable to afford them (2003: ii).

This might seem ironic to those who have tracked drug industry opposition to a Medicare drug benefit for years due to fear that it "would have to negotiate prices directly with the government just as hospitals and doctors do" (Siegel 2003b).<sup>329</sup> And the prospect of large profit is also a premise denied by some members of the industry. Ian Spatz, vice president for public policy at Merck said "no one's seeing any kind of big windfall for this" (Harris 2003c). There are no price controls measures in the bill due to drug industry success with arguments that they "would hurt their research and development" (Siegel 2003a). The purchasing power for Medicare prescription drugs will be split among dozens of different insurance companies. Responding to the question of why the federal government won't purchase Medicare drugs as they do for drugs for the Veterans' Administration, Princeton University Professor Uwe Reinhardt says:

..the answer's pretty simple: the drug industry has just said no to that idea. And the drug industry, putting it crudely, does have a sizeable equity stake in the Congress. So the Congress is unlikely to do something that the drug industry opposes (Siegel 2003b).

Conflicts of interest<sup>330</sup> and market language in this context may be also illustrated by the AARP. With its 35 million members and "hundreds of millions of dollars in annual income from the sale of health insurance and other products," AARP is "perhaps the wealthiest and most influential advocacy organization" in the United States (Stolberg and Freudenheim 2003). The AARP received more than one-third of its revenue from royalties paid by firms that market pharmacy services and insurance to

AARP (Smiley 2003). This advocacy organization is no stranger to the language of the market. Senator Trent Lott at one time derided AARP as “a wholly owned subsidiary” of the Democratic Party (Stolberg and Freudenheim 2003). Moments after voting against the Medicare bill, Democratic Senator John D. Rockefeller, IV said: “The AARP is a business, first and foremost. They have a product to sell” (Stolberg and Freudenheim 2003). As the AARP’s membership has become younger,<sup>331</sup> baby boomers were given as a significant reason for AARP’s shifting sensibilities on Medicare. Possible fault lines of conflict thus run between the needs of younger and older AARP members and along a continuum of democratic ideals of a membership organization to pragmatic considerations about revenue streams.

Intersections between trends in the political economy of transnational pharmaceutical corporations, global trade agreements, intellectual property rights, privatization, deregulation, and mass media juxtaposed with the reiterative health discourse used by the pharmaceutical industry and medicine make this a complex narrative with many threads. What is stunning about descriptions of elderly couples deciding who will get medicine on a particular day in 1959 or being forced to “choose” between medicine or food in 2003 is how little things have changed in fifty years and how little evidence there is that things will be different fifty years hence. Although a “Willie Sutton” counterfeiting Viagra does exist even in Waikiki,<sup>332</sup> the imagery of individual outlaws as Willie Sutton figures mixing up drugs in their kitchens or receiving kickbacks from drug companies tends to focus attention on a very narrow problematic. A pattern of market fundamentalism is to demonize individuals for transgressive behavior even as they are merely following the culture of liberalism to its logical conclusion as discussed in Chapter Four. Food and Drug Administration attempts to steer concern toward safety of imported proprietary products that are alleged to be counterfeit diverts attention from more complex questions about access to

socially produced therapies that are contingent on a primacy given to market relationships. In the spirit of Bertolt Brecht, what's counterfeiting Viagra compared with being CEO of Pfizer? What's counterfeiting Viagra compared with inventing it? Or marketing it? Or prescribing it?

Is ability to pay as the definitive determinant of access to pharmaceuticals<sup>333</sup> an optimal way to organize opportunities for health and life for ourselves, those we hold dear, and those we who hold far? The global pharmaceutical industry's sophisticated public relations campaigns diverting focus from the price of drugs to the cost of research or their concern about patients' safety or complex factors that impact access serve to normalize market fundamentalism. Drugs for neglected diseases, Kefauver's investigations, the joint hearing on the Comprehensive Child Immunization Act, prescription drug imports from Canada, and Medicare reform are all examples of the industry's creating a "fundamental double bind."<sup>334</sup> One part of the bind is to deny there is a problem or alternatively state that it is not "our problem" and then the clincher is to organize a response so that others are effectively prevented from solving the problem as well. This move is contingent on an acceptance that fidelity to market sensibilities does not allow any questioning of why economic relations should be privileged over social relations.

It is important to recognize these dynamics that valorize the market over other possible values in that the global pharmaceutical industry,<sup>335</sup> with support from the United States, is actively working to export these norms across the globe. Congress is interested in challenging the price-control systems of foreign governments to such an extent that the Medicare bill "requires the Bush administration to apprise Congress on progress toward opening Australia's drug pricing system" (Becker 2003). A wedge to opening drug pricing systems was articulated by Dr. Mark McClellan using language favored by the drug industry. In a speech in September 2003, McClellan spoke of the



need for the costs of research and development to be global as the “benefits of American drug innovations” are global. “The United States is now covering most of these costs of developing a new drug to the point where it can be used by the population of the world,” Dr. McClellan said. “But it is clear to me that we cannot carry the lion’s share of this burden for much longer” (Becker 2003). While McClellan certainly does not speak for all physicians, his professional credentials as a physician and his role as commissioner of the Food and Drug Administration helped shift resentment from the pharmaceutical industry to the rest of the world coasting along on a free ride.

Setting one group against another is not accidental where market relations override social relations. The global pharmaceutical industry is a particularly vibrant example of deliberate exploitation of conflicting interests to paralyze public policy. The interests of the industry are conflated with those “we” who are paying “the lion’s share” are set against those of Australian, Canadian, European free-riders. The interests of the industry are conflated with those of researchers and clinicians pushing the frontiers of biomedical science are set against price controls. The interests of the industry are conflated with governments seeking economic development opportunities are set against those resisting intellectual property rights regimes that curtail generic drugs. The interests of the industry are conflated with affluent sick patients seeking access to the newest technologies are set against poor sick patients seeking access to basic medications.

It is important to return here to the hegemonic power of modern medicine discussed in Chapter Two. The whole system of biomedicine is so demand driven that not prescribing is not much of an option to our sensibilities. Much of the ritual of seeking professional medical advice involves the physician as healer/priest dispensing prescriptions/communion to transform the patient/pilgrim from sickness/sin to health/grace. The rote may now be secular but the dynamics are parallel. While the

ritualized pattern may be familiar, the ascendancy of the market as discussed in Chapter Four has accelerated the commodification of nature, people, and formerly intangible elements such as health, love, and sex. Viagra and its brother products have been discussed as examples of a marketing phenomenon. These substances could be discussed as performance enhancing drugs that are particularly congruent with a culture where individuals must market their individuality<sup>336</sup> relentlessly (Elliott 2003). In addition to treating a biological condition and as a recreational drug, Viagra has been described as essential as “having snow tires on your car in a blizzard-prone region” (St. John 2003). As this 41-year-old New York City lawyer explains, his use of Viagra is a way to deal with “performance anxiety” in a context where appearance, performance, and money are linked:

“In this city there’s a lot of pressure to look good, to make money and to perform well,” Mr. London said, “It’s just one more added thing to give more masculine, virile attributes and to have that insurance” (St. John 2003).

What is lost by fixating on the Willie Suttons in various contexts is a sense of the adversarial frontier that creates demand in the first place.

CHAPTER SIX  
WE ARE ALL DEAD IN THE END BUT MEANWHILE HEALTH CARE SYSTEMS  
REFORM

...we have considerable latitude to alter our individual and collective states, if not our fates (for in the long run, as Keynes famously put it, we are all dead). Health issues are often at the center of public debate because health is usually defined more as a public good than a market commodity (particularly outside the United States). As a result, health policy is a powerful instrument that can literally shape destinies (Lewis, Saulnier, and Renaud 2000: 509).

This is a chapter of paradoxes. We are all dead in the end and yet it still seems to matter intensely how we live individually and collectively before then. Limits to life expectancies in industrialized countries are said to be broken at the same time as health care systems are lamented in their state of crisis. Efficiency, quality, and equity will be introduced as commonalities of health care reform at the same time as foreshadowing will suggest divergences in how these are interpreted. Claims that the United States has “the best health care system” in the world will be evaluated using markers of efficiency, quality, and equity. A close examination of cross-national data will confirm that higher health spending does not lead to higher health status and that universal access to health care does not guarantee universally good health.<sup>337</sup> While it may seem obvious that health care systems are about health, the latter part of this chapter will suggest that it makes a difference whether health is constructed as a human right, public good, or commodity.

Rhetoric and Dynamics of “Crisis” Common to Health Care Systems in Postindustrial Nations in the Early 21<sup>st</sup> Century

If “health” is not innocent, as argued in Chapter Two, then “crisis”<sup>338</sup> is even more complicit as a rhetorical tool in disputes over contested public policy terrain in realms such as national security, the environment, poverty, education, the economy,

federal, state, and municipal budgets, natural resources, and crime. While modern mass media have increased the ubiquity of the rhetoric of crises, the social construction of “problems” to further professional interests is not a new phenomenon. Historical examples have been powerfully illustrated by Michel Foucault’s genealogies of madness (1965), crime (1977), and sexuality (1978). The “problem” of a “health care crisis” with subsequent appeals for a solution described as “health care reform” is endemic as discourse about medical care systems in postindustrial nations<sup>339</sup> at the turn of the 21<sup>st</sup> century. Three objectives common to health care reform initiatives are efficiency, quality, and equity.

#### Efficiency: Demography, Technology, and Expectations as Cost Drivers

For many of the reasons described in Chapter Four, the financing of medical care became a major outlay in the budgets of mature welfare states just as neoliberal political regimes increased “fretfulness about the affordability, desirability, and governability of the welfare state” (Marmor 1997: 359). Described by one public policy analyst as an “epidemic of health reform sweeping across Western industrialized countries” (Chinitz 1997: 236), more than one scholar of health policy has noted that reform efforts, no matter how they are marketed, tend to be overwhelming about reducing or controlling expenditures on health and cutting budget deficits (Bjorkman and Altenstetter 1997: 2) (Rigoli and Dussault 2003: 2). This macroeconomic objective is often framed as a drive for “efficiency,” which threatens to become an end in itself with cult-like<sup>340</sup> properties (Stein 2002).

The limits of the human life span have become increasingly less finite to the extent that the concept of the “plasticity of longevity” has evolved (Robine 2002: 91). In the 1960s the limit of the human life span was thought to be 110 years. Ten years later

the marker indicating the probability of death reaching 100% was postponed to 115 years of age. Since the 1990s the "mortality trajectory no longer reaches 100%....Rather than a maximum life span, the mortality rate for frail old persons appears to be around 60% per year" (Robine 2002: 91). The end point of this trajectory still seems to be death with "only the slope" being in question (Evans, McGrail et al. 2001: 161). A different metaphor that has been used is "broken limits to life expectancy" as researchers note that increases in life expectancy among the best performing cohorts have steadily increased by almost three months per year for 160 years (Oeppen and Vaupel 2002). These demographers project female life expectancy in the United States in 2070 to be between 92.5 and 101.5 years, which is much higher than the Social Security Administration's projections of 83.9 years published in 1999 (Oeppen and Vaupel 2002). In this analysis, "centenarians may become commonplace within the lifetimes of people alive today."<sup>341</sup>

The percentage of people over 65 years of age in Canada rose from 7.5% in 1960 to 12.6% in 2001; the corresponding percentages in the United States increased from 9.2% in 1960 to 12.4% in 2001. In 2001, Germany and Belgium had 16.9% of their populations over 65 years of age, while Sweden had 17.2%, Japan had 17.8%, and Italy had 18.4% (OECD 2003b). Although the rates of decline in physical and mental health in modern, industrialized countries are now not considered to be physiologically determined as growing numbers of "healthy" older people can attest, there is an intuitive link often made between older populations and higher health care costs. Data from OECD countries shows that health expenditures for people over 65 years of age or more is three to five times higher than for those 0-64 years of age (Jacobzone 2002: 40).

The implications of a graying population for health and social services are surprisingly more nuanced and contested than they first appear. An aging population, especially among those described as "frail elderly" who are over 80 years of age, has

been described by OECD analysts as “the growing health burden” (OECD 1994: 1). In contrast to the language of “burden,” other OECD publications look to an aging population as experienced human resources to ameliorate slower economic growth, labor shortages, “escalating welfare bills” (OECD 2003a), and a “looming pension crisis” (OECD 2004).<sup>342</sup>

On one side of this contested spectrum are proponents of “apocalyptic demography”<sup>343</sup> raising the specter of “baby boomers busting the health budget” (Robson 2001). It is assumed in this model that older, sicker people will need more medical care that is increasingly expensive.<sup>344</sup> An assertion that then sometimes follows is “relentless demographic trends make universal public health care systems ‘unsustainable’” and their collapse “inevitable” thereby justifying privatization of health care financing and medical service delivery (Evans, McGrail et al. 2001: 187).<sup>345</sup>

In contrast to this view, critics of the “Doomsday Prophecy” (Jacobzone 2002: 42) argue “most empirical results show that ageing, in itself, is not a strong driver of health-care costs” (Jacobzone 2002: 38).<sup>346</sup> Sweden and Japan, for example, have higher percentages of elderly people but spend less on health expenditures than the United States with a younger population (Jacobzone 2002: 43). Rather than identifying aging as “the key problem,” Jacobzone argues that the diffusion of technology, “supply-side and institutional characteristics of social and health systems,” and the “high cost of dying”<sup>347</sup> are essential elements contributing to health care expenditures (2002: 43). Evans et al. point out that that gloomy and more sanguine projections about health expenditures are contingent upon contrasting underlying assumptions about 1) human organisms and our natural lifespan; 2) determinants of health and the extent to which they lay inside or outside the health care system; and 3) clinical decision making, including the effectiveness and intensity of medical response to patients’ conditions (2001: 163-164). Health Canada<sup>348</sup> projects that an aging population in Canada will contribute to an

increasing percentage of the growth in health care expenditures for the years 2001-2030 but will account for less than 30% of the total projected growth (Kirby 2002: 11).

Technology<sup>349</sup> as a driver of increasing health care costs, like aging populations, is more complicated than it may first appear. Evidence of whether technology increases<sup>350</sup> or decreases<sup>351</sup> health care costs is mixed or inconclusive<sup>352</sup> while the risks versus benefits of various technologies are often debated in the academic literature<sup>353</sup> and by clinical practice variations.<sup>354</sup> Technologies may be “embodied” in that they are contained in physical artifacts such as drugs; devices, equipment and supplies ;<sup>355</sup> medical and surgical techniques;<sup>356</sup> and support systems.<sup>357</sup> This may be contrasted with “disembodied” technologies “that do not involve a tangible product or piece of equipment” such as ideas<sup>358</sup> and procedures<sup>359</sup> (Kirby 2002: 37). While some of the disembodied technologies may be low cost and effective, such as health care workers washing their hands between patients to prevent nosocomial infections,<sup>360</sup> these basic technologies may sometimes be overshadowed in clinical practice by the glitter of more glamorous, complicated, and expensive interventions that are product or equipment based.

The mapping of the human genome, identification of disease genes, animal cloning, the amplification of DNA sequences through *in vitro* polymerase chain reaction (PCR) techniques (Ho and Gibaldi 2003: 4), and the rise of “bio-informatics” as a sub-discipline of computer science to analyze voluminous amounts of data (Morgan and Hurley 2002: 4) have helped to launch the “Biotech Age”<sup>361</sup> (Oliver 2003b) or “the era of post-genomic science” (Morgan and Hurley 2002: 4). As the study of genomics<sup>362</sup> identifies genes and proteins related to specific diseases, the race is on to find “technological magic bullets” that target specific cells without destroying healthy tissue (Morgan and Hurley 2002: 5). Embedded technologies that have arisen or will arise from genomics include not only bio-pharmaceuticals and genetic therapies but also genetic

testing for surveillance<sup>363</sup> and pharmacogenomics.<sup>364</sup> Targeting of pharmaceutical products to people with specific genotypes will increase cost as valued outcomes become more certain with customization and the overall market for a product is reduced by genotype specificity. A related scenario is that genetic testing may identify new markets for particular therapies so that treatment guidelines may include not only those who actually have a treatable condition now but also those at risk for a disease by genetic propensity (Morgan and Hurley 2002: 6-7). It is anticipated that genetic screening may also increase the demand for diagnostic imaging such as computed tomography (CT) scanning, magnetic resonance imaging (MRI), and positron emission tomography (PET) imaging in order to monitor people deemed at risk by their genetic make-up for cancer and other diseases (Morgan and Hurley 2002: 8).

On the other hand, embedded technologies that are so dependent on market forces may develop or not develop in unpredictable ways. While 2003 saw a flurry of publications with the theme of “how to profit from technology investing” (Abate 2003) (Oliver 2003b), by February of 2004 the question “Is Biotechnology Losing Its Nerve?” was being posed in the *New York Times* (Pollack). Investors unwilling to wait for ten years or more for profits from “molecule-to-market” companies have switched to “backing companies that can move product to market faster” (Pollack 2004).<sup>365</sup> This work, described as “doing therapeutics around the edges,” is essentially recycling old drugs by “repurposing” them until the possibilities are exhausted. This leaves the query posed by Drew Senyei: “At some point you are going to run out of late-stage companies, and the question is, who will fund the discovery companies?” (Pollack 2004)

A third factor in this mix of aging populations and increasingly sophisticated technology that has an impact on health care expenditures is a knowledgeable cohort of patients/clients/consumers/citizens that have consumerist expectations. Heartened by social movements (such as the women’s health movement, which in turn was influenced



by feminism, civil rights, and peace movements (Weisman 1998: 68)) and informed by expert and peer sources on the Internet and other mass media, people negotiate their relationship with the health care system differently now that "empowerment" has become a common term. This is not to say that power/knowledge differentials between physicians and patients or even gradients between different patients do not exist. While many people in Canada and the United States may have an increased amount of health information easily accessible to them, underlying questions about the significance of what it means to be a human being in a body are not always addressed. Consider how unusual the following passage by internist Beach Conger, MD seems to current sensibilities:

When a patient arrives in my office I put this cuff around his arm and pump it up. "You've got hypertension," I say. The patient says, "That's the silent killer," and we start down the long, long road of antihypertensive treatment. Now the fact that everybody's going to die, and that there may be a point in the patient's life when having hypertension is the best option available because it's better to die of a heart attack than get Alzheimer's disease, is not an option that's discussed. I had an eighty-nine-year-old woman come into my office and ask to have her cholesterol checked, and I refused. She said, "What do you mean? You can't refuse." I said, "No, but can I talk you out of it?" She said, "Well, I don't want to have a heart attack." I said, "Why not?" "I don't want to die." "What are your options at this point? You're eighty-nine years old." "Well, I'd like to die in my sleep." "How do you die in your sleep?" "I don't know." I explained, "Your heart stops. You need to have a heart attack, and high cholesterol is the best thing you can have. This is what you want!" I'm joking, but in another sense, I'm not (Mullan 2002: 70-71).

Ordinary people making up "the public" are often in a double bind in that they are criticized as "worried well"<sup>366</sup> for taking up medical resources unnecessarily even as they are criticized for not being "responsible" in promoting their own health by monitoring and regulating behaviors often described as "lifestyle choices."<sup>367</sup> The example of the man with hypertension, "the silent killer," is all the more salient given that the American parameters for healthy blood pressure have dropped so what was once "normal" at 120/80 is now "pre-hypertension" according to the National Heart,

Lung, and Blood Institute (Poole 2003).<sup>368</sup> Those with a propensity to be worried have more to worry about as what is well has an ever-narrow definition that is increasingly under surveillance by medical professionals. At the same time, both of the patients in this passage, according to health promotion lore, are acting responsibly by seeking advice and treatment for potentially lethal risk factors that must be determined by technological means. Seeking assessment is a first step to being a compliant patient and responsible citizen as long as there is something “really” wrong, even though this wrongness may be invisible when looking in the mirror at home.

Conger, described by Mullan as a “professional contrarian” (2002: 59), is remarkable in his recognition of what is not being talked about—we are all going to die. This may be obvious at a cognitive level but it is counterintuitive within a consumer culture that valorizes youth and a medical culture that usually regards death as failure rather than as a stage of life. Many physicians would have quickly given this person a laboratory requisition rather than ask why this was important to her. Asking “what are your options at this point?” helped that woman and us imagine the unimaginable, at least for a few moments. This trajectory towards pondering mortality and what makes the days we have meaningful is a values kind of discussion that gets to the core of grappling with the “infinite demand for health.”<sup>369</sup>

Of course, given notions of the “plasticity of longevity” and lowered norms for acceptable cholesterol levels (Kolata 2004), maybe a quickly dealt lab slip would assist her quality of life for the next twenty five years. Maybe it is too soon to be fluffing a pillow for a final nap. Even if both these patients are resolved to “go gently”<sup>370</sup> into life’s last stages, who knows whether in fact hypertension and high cholesterol will cause them sudden death heart attacks rather than debilitating strokes requiring admission to a nursing home? Conger’s stories demonstrate the effectiveness of social and industrial marketing, which has made hypertension “the silent killer” and increased demand for

cholesterol screening, while missing the eventual outcome of death as a part of life. In addition to illustrating some of the dynamics driving the infinite demand for health, this passage could also be viewed as a cautionary tale of how we, those who are preoccupied with public policy, are limited by our ignorance of any unintended consequences of judging the quality and value of other people's lives.

From his perspective as a medical historian, Roy Porter argues that "responding responsibly" to increasingly market-orientated and "patient-centered" demands "is the greatest challenge facing the medical profession as it advances into the new millennium" (Porter 2000: 1093). Aging baby boomers are a lucrative target for the purveyors of embodied technologies such as drugs and diagnostic imaging.<sup>371</sup> Going back to discussions of globalization in Chapter Four and the pharmaceutical industry in Chapter Five, "the culture of prescribing"<sup>372</sup> is increasingly affected by requests from patients influenced by direct to consumer advertising. This is illustrated by the diffusion of direct-to-consumer advertising that drifts across the border from the United States (where it is legal) to Canada (where it is not). In both Sacramento, California and Vancouver, British Columbia, survey results suggested that more advertising leads to more requests for advertised medicines and more prescriptions, often despite physician ambivalence (Mintzes et al. 2003). Within the logic of the marketplace, drivers of health care costs are many while disincentives to expenditure are few.

Three Views on Quality:<sup>373</sup> World Health Organization, Commission on the Future of Health Care in Canada, and Committee on Quality of Health Care in America

Then Director of the World Health Organization, Gro Harlem Brundtland, introduced the controversial<sup>374</sup> *World Health Report 2000 Health Systems: Improving Performance* by outlining the stakes:

The way health systems are designed, managed and financed affects people's lives and livelihoods. The difference between a well-performing health system and one that is failing can be measured in death, disability, impoverishment, humiliation and despair (WHO 2000: vii).

If one accepts that health involves a "description of 'the good life' as a moral state of affairs" (Turner 2000: 9) and is willing to accept that health system failure results in "death, disability, impoverishment, humiliation and despair," then the use of value-laden terms such as "goodness" and "fairness" to define health system performance is intelligible. "Goodness means a health system responding well to what people expect of it; fairness means it responds equally well to everyone, without discrimination" (WHO 2000: xi). Performance is then indexed comparatively by measurement of three overall goals: improving health and reducing health inequities, responsiveness to the expectations of the population, and fairness of financial contributions. The overall health system performance ranked by eight measures as well as level of health performance and fairness of financial contribution for selected countries may be found in Table 6.1.

**Table 6.1 World Health Report 2000 Level of Health Performance, Fairness of Financial Contribution to Health System, and Overall Health System Performance Rankings for Selected WHO Member States, estimates for 1997\***

Country	Level of Health Performance	Fairness of Financial Contribution	Overall Health System Performance
France	4	26-29	1
Japan	9	8-11	10
United Kingdom	24	8-11	18
Sweden	21	12-15	23
Germany	41	6-7	25
Canada	35	17-19	30
Australia	39	26-29	32
United States	72	54-55	37
Cuba	36	23-25	39
New Zealand	80	23-25	41
Sierra Leone	183	191	191

\*Source: (WHO 2000: 143-191)

The final report of the Commission on the Future of Health Care in Canada (Romanow 2002: 150) chose to cite a description of quality from the Saskatchewan Commission on Medicare's report called *Caring for Medicare: Sustaining a Quality System*:

Essentially it boils down to doing the best job possible with the resources available. It means achieving stated goals and targets. It is measurable against accepted and valid standards. It is incompatible with waste, duplication, and fragmentation. It is about minimizing underuse, overuse, and misuse. It is not about heroic effort or the futile pursuit of the impossible. It is unlikely to be achieved by a demoralized workforce or inadequately trained personnel. It does not thrive where there is conflict or lack of consensus on goals and mission. It is about leadership, goal setting, teamwork, process, measurement, commitment, incentives and accountability (Fyke 2001: 44-45).

This health policy desideratum may be briefly stated as a desire for excellence that is measured by interventions that are meaningful pursuits of the possible within a system of finite resources.

The Institute of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"<sup>375</sup> The first report of the Institute of Medicine's Committee on Quality of Health Care in America focused on building a safer health system by addressing clinical iatrogenesis. They define medical errors as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim" (2000: 28). Extrapolating from two major studies used in this report, at least 44,000 and perhaps as many as 98,000 people die each year from preventable medical errors (Institute of Medicine 2000: 26). This does not include mortality from nosocomial infections which is modeled to be the fourth to thirteenth leading cause of death in the United States depending on assumptions about attack and mortality rates<sup>376</sup> (Wenzel and Edmond 2001).

A second report from the Committee on Quality of Health Care in America addresses "not just a gap, but a chasm" that lies "between the health care we have and

the care we could have” (Institute of Medicine 2001: 1). Six aims articulated by this Institute of Medicine committee are that health care should be:

1. *Safe*—avoiding injuries to patients from the care that is intended to help them.
2. *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
3. *Patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
4. *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
5. *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status (2001: 5-6).

As a means to achieving these aims, the Committee on Quality of Health Care in America recommended that “all health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose” a “single, overarching purpose for the American health care system as a whole” (Institute of Medicine 2001: 6). The statement of purpose endorsed by the Committee on Quality of Health Care in America was explicitly adopted from the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998: 7):

The purpose of the health care system must be to continuously reduce the impact and burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.

This purpose, which physicians as a professional group are enjoined to embrace, is, like world peace, difficult to argue against. If improved health and functioning of ALL the people in a given society is a consensual purpose, value, or destination, the next question must be: to what extent then is the health care system under review actually organized to make this purportedly desired outcome possible?

## Equity: Health and Health Care Inequities as Outcomes of Social Hierarchies

As demonstrated within the aims of the Committee on Quality of Health Care in America, more comprehensive views of optimally performing health systems consider equity to be a constitutive characteristic indicative of quality. A clarifying distinction within health sector reform literature has been made between vertical equity (health care available as a function of need, not income) and horizontal equity (equal need should entail equal treatment) (Rigoli and Dussault 2003: 3). While illustrations of both vertical and horizontal equity in health care systems will be discussed, it must be reiterated that equity itself is a determinant of health.

Paula Braveman, MD, MPH, affiliated with the Center on Social Disparities in Health at the University of California San Francisco, defines equity as follows:

Equity means fairness or justice. Because these terms are open to interpretation, an operational definition is needed to guide measurement in diverse settings. In operational terms, pursuing equity in health can be defined as striving to eliminate disparities in health between more and less-advantaged social groups, i.e. groups that occupy different positions in a social hierarchy. Health inequities are disparities in health or its social determinants that favour the social groups that were already more advantaged. Inequity does not refer generically to just *any* inequalities between *any* population groups, but very specifically to disparities between groups of people categorized *a priori* according to some important features of their underlying social position. For example, individuals may be grouped by their income or material possessions, or by characteristics of their occupations, education, or geographical location, or by their gender, race/ethnicity, or religious group. What all of these factors have in common is that they often are strongly associated with different levels of social advantage or privilege as characterized by wealth, power, and/or prestige (Braveman 2003: 182).

Tracking disparities in health status upstream so that they may be viewed as manifestations of social injustice within hierarchical societies is inherently difficult.

Chapter Two describes how the Prussian government ignored the findings of Rudolf Virchow's investigation into the typhus epidemic of 1847 that it had itself commissioned. Chapter Three's Exhibit 3.3 outlines the ambivalence generated by Marc Lalonde's *A New Perspective on the Health of Canadians* in 1974 while Exhibit 3.1 marks the

Lalonde's *A New Perspective on the Health of Canadians* in 1974 while Exhibit 3.1 marks the "frosty reception" that greeted the *Black Report's* description of health inequities in the United Kingdom in 1980 (Townsend, Whitehead, and Davidson 1992: 3). Practices of equity lag far behind its rhetoric and theory as the Global Health Equity Gauge Alliance argues:

Equity was a key principle of the 1978 Alma Ata Declaration on Health for All. Despite study findings showing wide and sometimes widening disparities among and within countries on every continent, few countries routinely assess or monitor equity in health, and even fewer can demonstrate effective action to address inequalities when information is available (McCoy et al. 2003: 274).

Although evidence documenting the significance of economic and social disparities for health outcomes has been growing,<sup>377</sup> willingness to monitor inequalities and implement public policies to ameliorate morbidity and mortality linked with hierarchies has been variable. International health organizations such as the World Health Organization and the Pan American Health Organization have supported transnational research and policy initiatives on health disparities in Europe (Wilkinson and Marmot 2003) as well as Latin America and the Caribbean (PAHO/WHO 1999). While the governments of Australia<sup>378</sup> and New Zealand<sup>379</sup> have documented policy initiatives on health inequities, the United Kingdom provides perhaps the most well accessible illustration of an industrialized country that has constituted equity as integral to reform of its health care system as well as essential as a social determinant of health.

Two decades after the *Black Report* was commissioned, a "distinguished former Chief Medical Officer," Sir Donald Acheson, was commissioned in 1997 to chair an independent inquiry into evidence of health inequalities and suggest priority areas to reduce health inequities (DOH UK 1999: 2-3) (Acheson 1998). This work informed the "comprehensive Government wide public health strategy for England" that is outlined in the White Paper, *Saving Lives: Our Healthier Nation* (Secretary of State for Health 1999)



and “Our Healthier Nation” campaign.<sup>380</sup> Within this framework, it is then legitimate for investigators to frame as a research question pertinent to health: “what if Britain were more equal?” Three government policies are estimated to have the potential to reduce the proportion of deaths for people under 65 years by 10% annually in Britain: a mild redistribution of wealth would save 7,597 lives, achievement of full employment would save 2,504 people, and eradication of child poverty for children ages 0 to 14 years would save 1,407 lives annually (Mitchell, Shaw, and Dorling 2000).

The compelling force of life’s inequities embodied in flesh may be powerfully illustrated by considering the health status of indigenous people in Australia, Canada, New Zealand, and the United States. Expressions of racism manifest as genocide, colonialism, and loss of traditional cultures, livelihoods, and environments have translated into life expectancies that are six to twenty years shorter for aboriginal peoples than their national counterparts.<sup>381</sup>

**Exhibit 6.1 Selected Indicators for Aboriginal Peoples in Australia, Canada, New Zealand, and the United States, 2001\***

Indicator	Australian Aboriginal	Canadian Aboriginal	New Zealand Maori	Native Americans
% of total population	2.3	4.3	14.0	1.5
Urbanization (%)	37.0	49.5	60.0	56.0
Median annual income (\$US)	7180	16640	7920	21620
Unemployment (% of active population, excluding social assistance)	26.0	24.0	10.0	14.6
Employment Rate (>16 years old)	44.0 (includes workfare)	44.3	56.0	data not available
Speaks aboriginal language at home	13.3	29.3	15.0	23.0
Left school < 16 years	40.0	48.0	56.0	data not available
University Degree	2.6	3.3	4.0	11.0
Infant Mortality per 1000	14.0	11.6 <sup>382</sup>	7.5	8.3
Diabetes (%)	24.0	see <sup>383</sup>	30.0	11.0
Male Life Expectancy	56.0	68.2	67.2	67.6
Female Life Expectancy	63.0	75.9	71.6	74.7
Life expectancy difference with overall population, male and female (average)	20.1	5.8	8.6	6.1

\*Adapted from (Papillon and Cosentino 2004: 25), which was adapted from (Kauffman 2003: 4).

While reforming health care systems in Australia, Canada, New Zealand, and the United States to make them of higher quality and more accessible for indigenous peoples is necessary, it is not sufficient to address ill health and early death generated by centuries of social injustice.

#### Efficiency, Quality, and Equity in the Health Care System of the United States

While many American citizens might believe President George W. Bush's assertion that they have "the best health care in the world,"<sup>384</sup> scholars of comparative health systems often "wryly imply that if the US health system did not exist, it would

have to be invented as a model of everything national health system planners should avoid" (Chinitz 1997: 237). National health expenditures in the United States continue to grow from 15.5% of the gross domestic product in 2004 (\$1.79 trillion) to a projected rise of 18.4% of the gross domestic product in 2013 (\$3.35 trillion) (CMMS 2004). While this is clearly the most expensive way of delivering health care on the planet, does this system deliver health care that is "the best" when efficiency, quality, and equity are the criteria for evaluation?

A caveat to the following discussion is a reminder of the common practice of conflating health outcomes with medical interventions as outlined in Chapter Two. It is the underlying logic of the expropriation of health by medicine that simplistically attributes the health or non-health of a population with the characteristics of a particular health care system. Medicine and public health are necessary but not sufficient determinants of health that often overshadow careful consideration of important causal pathways that are embedded in social circumstances. Health systems are indeed significant but perhaps not to the extent commonly assumed. One might be surprised, for example, at findings suggesting that the health system in Valencia, Spain was responsible for approximately 47% of the total reduction in mortality from avoidable causes for the period 1975 to 1990 (Albert et al. 1996).<sup>385</sup> A dual consciousness, then, is needed to keep in mind the limitations of equating health with health systems while recognizing that this flawed fiction is the pragmatic undergirding of comparative health policy.<sup>386</sup>

So, if we suspend our recognition of the complexity of health determinants and focus exclusively on health systems, does the United States have the best health care system in the world? This is a vital question not only for the people of the United States but also internationally as market models of health care are being aggressively marketed across the globe (Fuller 1998) (Waitzkin and Iriart 2001).

For those who have experienced an upscale version of a modern American “doctors’ workshop,”<sup>387</sup> the “best health care in the world” may increasingly resemble a hotel, shopping mall, and theme park. Markers of opulence may stand in for quality of care as amenities such as atriums, valet parking, complimentary newspapers, in-room refrigerators, and concierges erase traditional distinctions between hospitals and hotels (Sloane and Sloane 2003). There is a national trend of new hospitals building private rooms rather than semi-private or ward accommodation<sup>388</sup> (Associated Press 2004a). With a “patient-centered” architecture and a mission to attract customers/clients, the claim is made that patients “are treated like royalty, or at least like hotel guests” (Sloane and Sloane 2003: 94).<sup>389</sup>

Since the first “medical mall” in Texas in 1974,<sup>390</sup> hospitals have increasingly fashioned themselves as malls, building on the mall’s familiar associations as beloved icon and familiar space of post-war America (Sloane and Sloane 2003: 91). Complete with teenage “mall rats” hanging around in the evenings, at Dartmouth-Hitchcock Medical Center

You can do your banking at the ATM in the small bank branch, drop off your dry cleaning, pick up a video, have your car serviced, and get a haircut while you wait for your doctor or family member. You can make travel arrangements, purchase a gift, or buy flowers. Of course, you could also try on new glasses and fill prescriptions at the pharmacy. A little something for everyone, and a hospital to boot! (Sloane and Sloane 2003: 86)

If you are fortunate enough to be admitted into one of those hospitals that “you may hate to leave,” (Sloane and Sloane 2003: 101) perhaps you might be lucky enough to be admitted to a unit that has the sensibilities of a theme park. The neuroscience unit on Queen Emma Tower 5 at Queen’s Medical Center in Honolulu, for example, is a 42,960 square foot, 40 bed unit, renovated at a cost of more than \$5 million (Altonn 2003). This “beautiful as well as healing environment” has a theme of “gathering places and water.”

The unit has incorporated design concepts around the world, such as Disney Institute's use of "on-stage and offstage areas" for theme park cast members...A key element is a bridge...that crosses over the fourth floor courtyard, taking people from the elevators directly to a water feature in the neuroscience unit. The corridors become off-stage areas to wheel patients around in privacy while visitors go to patients' rooms via the on-stage bridge (Altonn 2003)

Cook-Fort Worth Children's Hospital provides another example of Disneyfied space:

The atrium is walled with "lavishly embellished fairy-tale 'buildings' fashioned of drywall and imagination." The intent is to blend access and relaxation, creating enchanting spaces that comfort staff and engage children and visitors. Even the parking lot is a confection of a castle, with turrets and an illusionary drawbridge entrance, all concocted for a few thousand dollars. And, children are carried through these spaces not in old-fashioned wheelchairs but in little red wagons (Sloane and Sloane 2003: 109).

Moving beyond the charm of little red wagons and the sanitized experience of human suffering provided by offstage areas, does opulence of surroundings equal quality of care?

If one measures quality by access to technology, then the United States is clearly superior to Australia, Canada, New Zealand, and the median of OECD countries but falls behind Japan as shown in Table 6.2:

**Table 6.2 Use of Sophisticated Medical Technologies in Selected OECD Countries, 1999, 2000\***

	Australia	Canada	France	Japan	New Zealand	Sweden	UK	OECD Median	USA
MRI units per million pop., 2000	4.7	2.5	2.8	23.2	2.6	7.9	3.9	4.7	8.1
CT scanners per million pop., 2000	DNA	8.2	9.6	84.8	8.9	14.2	6.5	12.2	13.6
Coronary angioplasties per 100,000 pop., 1999	102.7	80.8	DNA	DNA	65.5	DNA	51.0	DNA	388.1
Patients undergoing dialysis per 100,000 pop., 2000	33.2	45.7	DNA	162.4	DNA	DNA	27.0	39.8	86.5

\*Source: Adapted from (Anderson et al. 2003: 99), original data from (OECD 2002).

The difficulty with this kind of data, of course, is that it does not provide insight into the medical necessity and effectiveness of the procedures. What does it mean that the United States performed four times as many coronary angioplasties and twice the kidney dialysis per capita than Canada?

A brief consideration of cross-border comparisons between the United States and Canada using the example of cardiac care suggests that this phenomenon is also more nuanced than it may first appear. Mark et al. (1994) have suggested that more aggressive patterns of cardiac care in the United States compared with Canada have been responsible for better quality of life after myocardial infarction. In their study Canadian patients had much lower rates of cardiac catheterization, coronary angioplasty, coronary by-pass surgery, and fewer visits to specialists. One year after myocardial infarction, the Canadian patients studied experienced more cardiac symptoms and worse functional status than their American counterparts (Mark et al. 1994). A meta-analysis of different patterns of care for acute coronary syndromes in the

United States and Canada, however, notes the evidence from four studies that greater use of invasive procedures in the United States does not confer a survival advantage (O'Shea et al. 2001: 19). In one study, for example, patients in the United States were up to eight times more likely to undergo coronary angiography, percutaneous transluminal coronary angioplasty, and coronary-artery bypass surgery thirty days after a heart attack than the study patients in Canada but the one-year mortality rates for both groups were identical (Tu et al. 1997). Assessments of quality of life and marginal utility of technology are complex as these authors, some of whom were involved in the Mark et al. study suggest:

We did find that Canadians were more likely to have chest pain symptoms. They had more limitations in their daily activities. They were even more likely to be somewhat depressed. But, when asked to rate their overall health, Canadians responded virtually identically to Americans. And when we assessed work status, Canadians were just as likely as Americans to be back working full time...Consistent with the view of health care as a field where half-way technologies predominate, neither surgery nor angioplasty offers much benefit on average to patients at medium risk of cardiac events. Instead, the vast majority would still be alive ten years later if they had simply been given drugs. The first consequence of marshalling half-way technologies, in a climate of uncertainty within highly variable local and national health care systems, is a great deal of variation in practice patterns and resource consumption. The second consequence is the phenomenon of diminishing marginal impacts on health status. We may start with a near linear relationship between service investments and improvements in population health status. But as service intensity rises, more and more resources are poured into achieving smaller and smaller gains (Naylor, Iron, and Handa 2002: 26-27).

The theme of practice variations will be revisited in Chapter 7 while the dilemma of diminishing returns for technology is a helpful underpinning of subsequent discussions of health care reform in this chapter.

Table 6.3 demonstrates how health care system reform efforts in industrialized countries have resulted in either "more efficient" ("less is more" model) or "less responsive" ("less is less" model) delivery of health services. Whatever the preferred interpretation of health care reform, across-country trends between 1990 and 2000 are

those of fewer acute care beds, fewer admissions for shorter durations, and fewer acute care hospital days per capita.

**Table 6.3 Health Services Capacity and Use, Selected OECD Countries, 1990, 2000\***

	Australia	Canada	France	Sweden	UK	OECD Median	USA
Acute care beds per 1,000 pop. 1990	4.4	4.0	5.2	4.1	DNA	4.3	3.7
Acute care beds per 1,000 pop. 2000	3.8	3.3	4.2	2.4	3.3	3.8	3.0
Admissions per 1,000 pop. 1990	168	120	209	166	DNA	163	125
Admissions per 1,000 pop. 2000	155	99	204	159	151	154	118
Average length of hospital stay (days) 1990	6.5	8.6	7.0	6.5	5.7	8.4	7.3
Average length of hospital stay (days) 2000	6.2	7.1	5.5	5.0	6.2	6.4	5.9
Acute care hospital days per capita 1990	1.2	1.4	1.5	1.1	0.9	1.2	0.9
Acute care hospital days per capita 2000	1.0	1.0	1.1	DNA	0.9	1.0	0.7
Physicians per 1,000 population, 2000	2.5	2.1	3.3	2.9	1.8	3.1	2.8
Physician visits per capita, 2000	6.4	6.4	DNA	2.8	5.4	5.9	5.8

\*Source: Adapted from (Anderson et al. 2003: 95, 97), original data from (OECD 2002).

Given the massive expenditure on health in the United States, it is then somewhat sobering to realize that the United States received less for its spending in terms of physicians per population, physician visits per capita, acute care beds per population, admissions per population, average length of stay, and acute care hospital days compared with the OECD median. People in the United States “are receiving fewer real resources than are people in the median OECD country:” in one confirmatory study for the year 1990, Americans paid an estimated 40 per more per capita than Germans but received 15 fewer “real health care resources” (Anderson et al. 2003: 101). The



conclusion to “what Americans are getting for their greater health spending” was summed up by these health economists in their article’s title and concluding sentence as “It’s the prices, stupid” (Anderson et al. 2003: 103).

Moving from counting inputs to evaluating health outcomes reinforces the notion that these high prices are not delivering anything even close to the “best health care system in the world.” Ironically, even proponents of market-based health care systems describe the United States as an “extreme case” of spending more for poor health outcomes with its outlier highest health expenditures and comparatively lower life expectancy than other industrialized countries (World Bank 1993: 54). A decade after the publication of *Investing in Health* (World Bank 1993), the United States has the same life expectancy at birth as Cyprus (77.3 years) for both sexes in 2002 which is not as good as 25 other countries. As Table 6.4 indicates, Cyprus spent \$932 per person on health expenditures in 2001 and had a better infant mortality rate (7 per 1000 for males in 2002) than the 9 per 1000 for the United States, which spent \$4887 per person. Cuba has approximately equivalent outcome indicators to the United States (slightly worse life expectancy, slightly better infant mortality) but spent only \$185 per person.

**Table 6.4 World Health Report 2003 Comparative Data on Life Expectancy at Birth, Probability of Dying Under Age 5 Years, and Per Capita Total Expenditures on Health for Selected Countries\***

Country	Life Expectancy at birth in years, both sexes, 2002	Probability of Dying (per 1000) under age 5 years, 2002, males	Per capita total expenditures on health, 2001, US \$
Japan	81.9	4	2627
Monaco	81.2	5	1653
San Marino	80.6	5	1222
Switzerland	80.6	6	3774
Australia	80.4	6	1741
Sweden	80.4	4	2150
Andorra	80.3	5	1233
Iceland	80.1	4	2441
Canada	79.8	6	2163
France	79.7	5	2109
Italy	79.7	5	1584
Singapore	79.6	4	816
Spain	79.6	5	1088
Austria	79.4	6	1866
Israel	79.4	7	1641
Norway	79.1	5	2981
New Zealand	78.9	7	1073
Luxembourg	78.8	5	2600
Germany	78.7	5	2412
Netherlands	78.6	6	2138
Belgium	78.4	6	1983
Greece	78.4	7	1001
Finland	78.2	4	1631
United Kingdom	78.2	7	1835
Malta	78.1	7	808
<b>United States</b>	<b>77.3</b>	<b>9</b>	<b>4887</b>
Cyprus	77.3	7	932
Cuba	77.1	8	185
Ethiopia	48.0	185	3
Botswana	40.4	104	190
Zimbabwe	37.9	115	45
Sierra Leone	34.0	332	7

\*Source: (WHO 2003: Annex Tables 1, 6)

From 1958 to 2001, the infant mortality rate in the United States has either decreased or stayed the same (Kochanek and Smith 2004: 4). As Table 6.5 indicates, the overall infant mortality rate increased from 2001 to 2002 from 6.8 to 7.0 infant deaths per 1,000 live births.

**Table 6.5 National Center for Health Statistics Data, Infant Mortality Rates in the United States, 2000-2002**

	Infant Deaths per 1,000 live births, 2000 <sup>a</sup>	Infant Deaths per 1,000 live births, 2001 <sup>b</sup>	Infant Deaths per 1,000 live births, 2002 <sup>c</sup>
All	6.9	6.8	7.0
White	5.7	5.7	5.8
Black	13.5	13.3 <sup>d</sup>	14.3
American Indian or Alaskan Native	8.3	9.7	
Asian or Pacific Islander	4.9	4.7	
Hawaiian	9.0	7.3	
Hispanic or Latino	5.6	5.4	5.6

a. Source: (Freid et al. 2003: 121)

b. Source: (Freid et al. 2003: 121)

c. Source: (Kochanek and Smith 2004: 20)

d. Infant mortality rate for blacks for 2001 was 14.0 according to (Kochanek and Smith 2004: 20).

Disaggregating infant mortality rates (or life expectancy as extensively discussed in footnote 46) by race/ethnicity further reveals that advances in lowering infant mortality rates have not been equally shared by all in the United States. In fact, one could argue that not only are health outcomes unequally distributed but health disparities are going worse. “The ratio of Black-to-White infant mortality has increased--from 1.6:1 in 1950 to about 2.4:1 in the 1990s” (Kington and Nickens 2001: 264). Table 6.5 indicates the Black-to-White ratio remained at 2.46:1 in 2002. With a 14.3 infant mortality rate, blacks in the United States fall internationally somewhere between Latvia and Seychelles at 15 and Belarus, Brunei Darussalem, and Qatar at 14 per 1,000 live births respectively (WHO 2003: 146-151).

Three ways of discussing quality of the health care system in the United States include: iatrogenesis, framed as the “safety agenda” by the federal agency charged with its amelioration; process indicators such as those found in RAND’s Community Quality Index Study; and outcome indicators such as “avoidable mortality” for specific conditions and “quality indicators” for medical care. The first of these points, “medical

errors and patient safety issues,” has been described by the director for the Agency for Healthcare Research and Quality, Carolyn Clancy, MD as “a national problem of epidemic proportions” (Clancy 2004: 1).

As mentioned earlier in this chapter, estimates of iatrogenic mortality used by the Institute of Medicine in the United States range between 44,000 to 98,000 annually (2000: 26). Even if one discounts Starfield’s outlier estimate of 225,000 annual iatrogenic deaths (2000), estimates of between 75,000 and 150,000 iatrogenic deaths annually in the United States (Bunker 2001: 1262) confirm the scope of this quality challenge. The Institute of Medicine attempts to put those deaths by preventable adverse events in context by situating them as exceeding those of deaths attributable to motor vehicle accidents, breast cancer, or HIV/ AIDS (2000: 26). Bunker contextualizes them by estimating a loss of life expectancy of six to twelve months as a result of iatrogenic deaths occurring during surgical and medical treatment (2001: 1262). Conservative<sup>391</sup> estimates of medication errors suggest that they account for one out of 131 outpatient deaths and one out of 854 inpatient deaths (Institute of Medicine 2000: 27). While it is difficult to compare the scope of this epidemic across countries, Congressional appropriations of \$165 million over three years leaves the Agency for Healthcare Research and Quality “proud to say that it is now the leading funder of patient safety research in the world” (Clancy 2004: 1).

Paradoxically, this ascent of “patient safety research” coincides with a decline in the common use of post mortem examinations as a mechanism of final surveillance:

In the mid-1940's, about half of Americans who died were autopsied. In 1984, the rate was about 13 percent; by 1994 it had dropped to 9.4 percent. A year later, the National Center for Health Statistics stopped collecting national autopsy statistics altogether, but most experts agree that the rate is now probably less than 5 percent (O'Connor 2004).

The significance of this trend of declining autopsies<sup>392</sup> for hospitalized patients is that missed or incorrect diagnoses get buried with the patients. Autopsies can be

“educational tools” especially in critical care medicine. Dr. Combes said, “It’s a difficult science, and you always learn from your mistakes. That is particularly true in the ICU, where deaths occur very frequently and very rapidly”(O’Connor 2004). Combes et al. conducted a 3-year prospective study of all consecutive autopsies<sup>393</sup> performed on patients who died at a Parisian university hospital medical-surgical intensive care unit. Major diagnostic errors were made in 53 (31.7%) of 167 patients. There were 171 missed diagnoses, including 21 cancers, 12 strokes, 11 myocardial infarctions, 10 pulmonary emboli, and 9 endocarditis, among others (Combes et al. 2004). A retrospective 2-year study<sup>394</sup> in a medical intensive care unit in a tertiary care hospital in Cleveland revealed a 19.8% discordance between the clinical cause of death and the postmortem diagnosis. In 44.4% of the discordant cases, therapy would have been altered with knowledge of the correct diagnosis (Tai et al. 2001).

Despite four decades of research documenting poor quality health care, “most people do not believe that there is a quality problem. Many think that the care delivered by their doctor, or in their community, is better than the care delivered in the nation as a whole” (RAND 2004: 4). The RAND Community Quality Index Study<sup>395</sup> found that the adults who participated in their study received about 55 percent of recommended care<sup>396</sup> with little difference in basic level of performance for acute, chronic, and preventive care (McGlynn et al. 2003). There were large variations by diagnosis in adherence to standard processes indicative of quality that ranged from 78.7 percent of recommended care for senile cataract to 10.5 percent of recommended care for alcohol dependence (McGlynn et al. 2003: 2635). Underuse of care was found to be a greater problem than overuse. Potentially harmful or not recommended care was received 11 percent of the time compared with patients failing to receive recommended care about 46 per cent of the time (RAND 2004: 2). The RAND Community Quality Index Study argues that quality standards matter in that the gap between what clinicians know to be effective

and the care actually provided can contribute to preventable complications and death as illustrated by Table 6.6:

**Table 6.6 RAND Illustration: “Why Quality Standards Matter”<sup>397</sup>**

Condition	Results	Potentially Preventable Complications or Deaths (Annual)
Diabetes	Average blood sugar not measured for 24%	2,600 blind; 29,000 kidney failure
Hypertension	Less than 65% received indicated care	68,000 deaths
Heart Attacks	35-55% did not receive needed medications	37,000 deaths
Pneumonia	36% of elderly received no vaccine	10,000 deaths
Colorectal Cancer	62% not screened	9,600 deaths

<sup>397</sup>\*Source: (RAND 2004: 4) with hypertension, heart attacks, pneumonia, and colorectal cancer data attributable to (Woolf 1999).

Avoidable mortality<sup>397</sup> is a population-based method of counting “untimely and unnecessary deaths from diseases for which effective public health and medical interventions are available” (Manuel and Mao 2002). A comparison of avoidable mortality in the United States and Canada from 1980 to 1996 showed that mortality for avoidable diseases groups decreased in both countries during the study period, although the rate of decline was more rapid in Canada. The important exception to this decline was asthma deaths in the United States, which increased by 79%, while deaths in Canada from asthma decreased by 56%. The United States had higher mortality ratios for 9 of the 11 disease groups studied. There was no difference in both countries in mortality from peptic ulcer while breast cancer mortality was slightly higher in Canada than the United States. The authors of this study discuss the lower mortality ratios for asthma, cervical cancer, hypertension and cerebrovascular disease, tuberculosis, and maternal mortality in the context of comprehensive health care freely available at the point of service and increased emphasis on primary care in Canada compared with the United States (Manuel and Mao 2002).<sup>398</sup>

While the unit of analysis in Manuel and Mao's comparative study was standardized mortality ratios calculated to adjust for the different age and sex composition of the United States and Canada, other scholars utilize other criteria in their comparative analysis. The Commonwealth Fund International Working Group on Quality Indicators, for example, uses indicators derived from five-year cancer relative survival rates, thirty-day case fatality rates after heart attacks and stroke, as well as avoidable events such as suicide, asthma mortality, and vaccine-preventable diseases. In the five country comparison illustrated in Table 6.7, "no country scores consistently the best or worst overall, and each country has at least one area of care where it could learn from international experience" (Hussey et al. 2004: 91-92). One example the authors give is asthma mortality, rates of which have been increasing in the United States<sup>399</sup> while declining in England and Australia "reflecting improvements in asthma care" (Hussey et al. 2004: 95).

**Table 6.7 Commonwealth Fund International Working Group on Quality Indicators, Standardized Performance on Selected Quality Indicators in Five Countries**

(Higher numbers indicate better results; 100 is the worst result)

Outcome Indicator	AUS	CAN	Eng	NZ	USA
Survival Rates (Outcome)					
Breast Cancer	107	104	100	106	114
Cervical Cancer	111	106	100	105	108
Colorectal Cancer	116	113	100	123	108
Childhood Leukemia, ages 0-15 years	100	118	109	102	110
Non-Hodgkin's lymphoma	116	107	100	115	109
Kidney Transplant	106	113	104	104	100
Liver Transplant	110	123	100	NA	102
Anterior myocardial infarction, ages 20-84 years	134	100	NA	121	NA
Ischemic stroke, ages 20-84 years	120	124	NA	100	NA
Avoidable Events (Outcome)					
Suicide, all ages	112	114	155	100	120
Suicide, ages 15-19 years	162	151	187	100	165
Asthma mortality, ages 5-39 years	144	NA	122	100	130
Pertussis	100	135	196	NA	191
Measles	187	198	100	160	199
Hepatitis B	167	133	168	167	100
Smoking Rate	111	115	100	106	115

\* Source: Adapted from (Hussey et al. 2004: 92)

Quality indicators discussed from the “supply-side” experts’ technical point of view may be juxtaposed with “demand-side” experts who experience health care services as patients. The Commonwealth Fund<sup>400</sup> reports that except for timeliness for hospital admissions and elective surgery, the “U.S. health care system performs relatively poorly from the patient perspective” (Davis et al. 2004: vii). Based on telephone surveys in five countries of a nationally representative, cross-sectional sample of approximately 1,400 non-institutionalized adults in each country in 2001 and approximately 750 sicker adults in each country in 2002, Table 6.8 illustrates sample items related to patients’ perceptions of care received. The Commonwealth Fund structured their examination of quality by using the Institute of Medicine’s framework of patient safety, patient-centeredness, timeliness, efficiency, effectiveness, and equity



described earlier in this chapter. Table 6.8 gives the summary ranking for comparison purposes.

**Table 6.8 Commonwealth Sample Items Indicative of Patients' Experiences of Quality Measures with Percentages Reporting for Five Countries, 2001, 2002**

Percent Reporting	AUS	CAN	NZ	UK	USA
<b>Safety (4 items):</b> Medication or medical mistake that caused serious health consequences in past 2 years (2002)	13	15	14	9	18
<b>Patient-Centeredness (5 items):</b> Physician fair or poor on listening carefully to patient's health concerns (2002)	9	10	8	14	17
<b>Timeliness (7 items):</b> Waiting time of four months or more for elective/nonemergency surgery (base: those needing elective surgery in past year) (2001)	23	27	26	38	5
Very difficult or somewhat difficult to see a specialist (2002)	41	53	36	38	40
<b>Efficiency (3 items):</b> Sent for duplicate test by different health care professionals, in past 2 years (2002)	13	20	17	13	22
<b>Effectiveness (4 items):</b> Did not get a recommended test, treatment, or follow-up due to cost, in past 2 years (2002)	16	10	15	5	26
Did not fill a prescription due to cost in past 2 years (2002)	23	19	20	10	35
<b>Equity (Below v. Above National Median Income):</b> Had medical problem but did not visit doctor due to cost in the past year <b>Below Average Income</b> (2001)	14	9	24	4	36
Had medical problem but did not visit doctor due to cost in the past year <b>Above Average Income</b> (2001)	10	3	18	2	15

\*Source: Adapted from (Davis et al. 2004: 5-13)

**Table 6.9 Commonwealth Fund Summary Ranking for Quality Measures for Five Countries, 2001, 2002<sup>401</sup>**

1 equals the highest positive score

	AUS	CAN	NZ	UK	USA
Patient Safety Measures, 2002	2.5	4	2.5	1	5
Patient-Centeredness Measures, 2002	2	3	1	5	4
Timeliness Measures, 2002	2	5	1	4	3
Efficiency Measures, 2002	1	4	2	3	5
Effectiveness Measures, 2002	4.5	2.5	2.5	1	4.5
Equity Measures (Below Average Income) 2001	2	3	4	1	5
Equity Measures (Above Average Income) 2001	4	2	3	1	5

\*Source: Adapted from (Davis et al. 2004: 5-13)

Having just considered the relatively poor performance of the United Kingdom on outcome measures such as cancer survival, liver transplants, and measles in Table 6.7, one might be surprised at the strongly positive experiences of patients resulting in highest ranking on patient safety, effectiveness, and equity measures. This positive assessment by patients does seem congruent with the relatively high ranking of the United Kingdom on overall health system performance by the World Health Organization (Table 6.1), which not coincidentally places substantial emphasis on equity. Noting the extent to which equity infuses such items as effectiveness in this matrix thereby conflating categories, it is still amazing that the “best health care system in the world” was consistently ranked for quality in the middle to the last based on the experiences of American patients.

The United States fares poorly when considering both vertical and horizontal dimensions of equity. Table 6.8 suggests deficiencies in vertical equity in all five countries as cost was a barrier to accessing medical care or prescribed medicines, with the United States consistently demonstrating significant barriers to care. Although the 36% of the below average income people in the United States who forewent a doctor’s visit is shocking compared with the 4% of below-average income patients who did not visit a physician in the United Kingdom, it is also remarkable that 15% of above-average income people also did not visit a doctor due to cost in the United States. This brings us to the topic of health insurance, which is a particularly vexing problem in the United States.

Despite an outlay of over \$1.55 trillion or 14.9% of the gross domestic product spent on health expenditures in 2002 (CMMS 2004), the percentage and number of people without health insurance in the United States increased from 14.6% in 2001 to 15.2% in 2002 to 43.6 million people. In 2002 there were 8.5 million children (11.6% of all children under 18 years of age) without health insurance (Mills and Bhandari 2003: 1).

Even though Medicaid insured 14 million people in poverty in 2002, 10.5 million other poor people (or 30.4% of people living in poverty) had no health insurance (Mills and Bhandari 2003: 4). The Kaiser Family Foundation points out that nearly two-thirds (64%) of the uninsured are from low-income families earning less than 200% of the poverty level (Rowland 2004: 6). The Census Bureau notes the erosion of employer-sponsored insurance coverage from 62.6% in 2001 to 61.3% in 2002 (Mills and Bhandari 2003: 3) and that 19,911,000 people who worked full time in 2002 were uninsured (Mills and Bhandari 2003: 21). A Robert Wood Johnson sponsored study noted that approximately 74.7 million people under the age of 65 years or nearly one out of three (30.1%) were without health insurance for all or part of 2001 and 2002 (Families USA Foundation 2003: 1).

While those with more income and more education are more likely to have access to health insurance,<sup>402</sup> there is growing concern about “uninsurable” middle class people faced with exorbitant health insurance premiums or denial of insurance altogether resulting in patterns of “middle class poverty”<sup>403</sup> and threats of bankruptcy<sup>404</sup> when medical catastrophes strike (Broder, Pear, and Freudenheim 2002) (Strom 2003) (Miller and Miller 2004). Ironically enough, there is a disturbing trend that even those who are integral to the health care system do not always have access to health insurance. Of health care workers under 65 years of age, 1.36 million did not have health insurance in 1998, which was an increase of 83.4% from 1988.<sup>405</sup> Health care aids, food service workers, cleaners, and laundry workers were most likely among health care workers to be uninsured, however, the percentage of physicians without insurance increased from 3.3% to 5.4% for a total of 31,000 uninsured doctors in 1998 (Case, Himmelstein, and Woolhandler 2002).

The logic of private health insurance is that it privileges the wealthy (those who can afford premiums and co-payments<sup>406</sup>) and the healthy (those who are vigorous

enough to work and those well enough to be considered low-risk from an actuarial point of view). Vertical equity in this framework is poor in that those who are most in need of medical care are least likely to be desirable as candidates for employment and/or private health insurance. People who are in “less-than-perfect” health face significant barriers in obtaining insurance coverage in the individual insurance market (Pollitz, Sorian, and Thomas 2001; Miller and Miller 2004).<sup>407</sup>

A growing body of literature<sup>408</sup> documents the sinister consequences of not having access to health insurance. An analysis by the Institute of Medicine (2003) estimated that uninsured adults have a higher risk of dying before 65 years of age than do insured adults, resulting in approximately 18,000 excess deaths annually. A review of 130 studies on health insurance as an independent variable and health-related outcomes for 18 to 64 year old adults concluded that those without health insurance were sicker, died sooner,<sup>409</sup> and received too little medical care too late that was substandard in quality. These findings were consistent when considering a range of medical conditions such HIV, cancer, cardiovascular and renal diseases, as well as mental illness and trauma. For example:

Uninsured persons with traumatic injuries are less likely to be admitted to the hospital, receive fewer services when admitted, and are more likely to die than are insured trauma victims. Provider response to traumatic injury can be influenced by insurance status. In one statewide study<sup>410</sup> of uninsured auto accident victims, uninsured patients were found to receive less care and had a 37 percent higher mortality rate than did privately insured accident victims (Institute of Medicine 2002a: 12).

Ethnic minorities are less likely to have health insurance than non-Latino whites, due to lower rates of job-based insurance (Brown et al. 2000: xi). While the percentage of uninsured for “all races” was 15.2% in 2002, a break-down for selected race/ethnicity/Hispanic origin by uninsured status is instructive: Hispanic (of any race) 32.4%; black alone 20.2%; Asian, Native Hawaiian and other Pacific Islander, either

alone or in combination, 18.1%; and white alone, not Hispanic 10.7% (Mills and Bhandari 2003: 7).

To exacerbate the situation for people who cannot afford or are denied eligibility for health insurance, uninsured people who do receive medical care from hospitals are typically charged two to four times as much for treatment as patients with health care insurance. For example, hospitals in Philadelphia charged an average of \$30,000 to treat a heart attack in 2002 while most insurers were ultimately asked to pay less than \$10,000 (Associated Press 2004d). While some analysts say “overbilling largely is caused by hospitals that are trying to recoup the growing costs of indigent care” (Associated Press 2004d), others describe it as uninsured patients being “charged 100 per cent of the full sticker price” as they are without access to volume discounts negotiated by governments or private insurers (Abelson and Glater 2004). Tax-exempt nonprofit hospitals, some described as being “among the most profitable hospital systems in the nation with hundred of millions, even billions, in assets and revenue” (Abelson and Glater 2004), are the subject of particular scrutiny from regulators, litigators, and the public as sticker-shock sets in. Aggressive bill collection practices by hospitals against people who do not have the means to pay has resulted in law suits<sup>411</sup> and complaints to state attorney generals (Abelson and Glater 2004). Vertical equity is poor as those who cannot afford insurance premiums are charged retail prices and then harassed by collection agents<sup>412</sup> commissioned by hospitals who identify “self-pay” patients as profit opportunities or “cash cows”<sup>413</sup> (Borger 2003).

The existence of publicly funded health insurance programs such as Medicare,<sup>414</sup> Medicaid,<sup>415</sup> and the State Children’s Health Insurance Program<sup>416</sup> does not necessarily level the playing field to ensure vertical equity. Gaps in coverage as well as ongoing impulses to save money by decreasing access to services may be illustrated with a few examples. Prior to Medicare, in the early 1960’s, seniors spent an average of 10% of their

income annually on medical care (Weiss 1997: 155). On average, the elderly spent an estimated 22% of their income for health care services and premiums in 2002 due to gaps in Medicare's coverage (Kaiser Family Foundation 2004b: 2). Lawrence Weiss argues that Medicare premiums, deductibles, and co-payments as well as well as habitual "fraud, misrepresentation, and exploitation of the elderly by a sizeable segment of commercial medigap insurers" means that Medicare beneficiaries "pay more and get less" (Weiss 1997: 154-155).

While access to Medicare is demarcated by requirements to be 65 years of age or be afflicted with a particular condition such as disability or end stage renal disease,<sup>417</sup> access to Medicaid is guarded by stigma inherent to applying to a "means-tested, residual welfare program"<sup>418</sup> (Wildavsky 1992: 318). Even for those willing and able to cross disincentives of humiliation<sup>419</sup> exacerbated by bureaucratic machinations,<sup>420</sup> access has been systematically restricted.<sup>421</sup> States facing "fiscal crisis" due to declining revenue<sup>422</sup> and increasing expenses<sup>423</sup> since 2001 "have increasingly focused on Medicaid as a key component of their efforts to balance their budgets" (Smith et al. 2004: i). Ray Scheppach, executive director of the National Governors Association, described the states' budget outlook in 2003 as "the bleakest" since the War of 1812. He said, "It's clearly the worst since we've been keeping statistics" (Wilgoren 2003). Scheppach argued that even if the economy were to pick up, the "virtual explosion" in Medicaid costs will keep the states in crisis: "It's the Pac-Man of state government" (Wilgoren 2003).

Although some of the pressure was relieved by \$20 billion in temporary federal fiscal relief for states enacted by Congress in May of 2003 (Smith et al. 2004), "quietly and painfully, most states are choosing to crimp the health-care safety net for their poorest and most politically defenseless residents" (Editorial: The Budget Politics of Being Poor 2003). As of November 2003, six states—Alabama, Colorado, Florida,

Maryland, Montana, and Utah—stopped enrolling children into their State Child Health Insurance Program (Ross and Cox 2003: 2). Three of these states<sup>424</sup> do not maintain waiting lists so it is difficult to quantify nationwide exactly how many children are affected by the freezes (Ross and Cox 2003: 4). The Center on Budget and Policy Priorities describes some of the specifics of the eroding of public insurance:

Some 34 states have adopted cuts that are causing 1.2 to 1.6 million low-income people to lose health insurance. Most of the cuts have affected children and parents in families in which the parents work at low-wage jobs. For example, Texas will end coverage under the Children's Health Insurance Program for nearly 160,000 children in working families, and Connecticut reduced Medicaid eligibility for parents with incomes from 100 to 150 per cent of poverty, with about 20,500 parents affected...New or higher copayments for public health insurance services were imposed by 21 states for fiscal year 2004; the previous year 17 states added or increased copayments. Research has shown that copayments are a significant deterrent to the use of essential medical care and prescription drugs among low-income populations, and that there are adverse health consequences when such treatment is foregone or delayed (McNichol and Harris 2004: 3)

While the evidence of imperfect vertical equity is overwhelming, there is also an impressive body of literature that tracks the goal of equal need corresponding to equal treatment or horizontal equity. Class works synergistically with other characteristics such as gender and race/ethnicity and yet even when class is discounted as a factor, disparities abound. Gender disparities may be illustrated by considering the exclusion of female subjects from study populations for medical research<sup>425</sup> (Doyal 1995: 85) (Ostlin, George, and Sen 2003: 143). Questions about systemic bias in clinical assessment and treatment were raised by such findings as a woman in the United States in the study period 1981-1985 had only 70 percent of the chance of a man of obtaining a kidney transplant<sup>426</sup> (Held et al. 1988). "The Yentl Syndrome"<sup>427</sup> (Healy 1991) has been used to describe the phenomenon of physicians pursuing a less aggressive management approach<sup>428</sup> to coronary disease in women than in men, despite greater cardiac disability in women (Steingart et al. 1991).

The Institute of Medicine's comprehensive report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, begins by juxtaposing the results of two opinion polls published in 2000 and 2001 that indicate that a significant majority of Americans believe that blacks receive the same quality of health care as whites with a "sharply contrasting reality:"

A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than white Americans. Relative to whites, African Americans—and in some cases, Hispanics—are less likely to receive appropriate cardiac medication or to undergo coronary artery bypass surgery, are less likely to receive hemodialysis and kidney transplantation, and are likely to receive a lower quality of basic clinical services such as intensive care, even when variations in such factors as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account. Significantly, these differences are associated with greater mortality among African-American patients (Institute of Medicine 2002b: 3).

This IOM report which helped to achieve "some level of consensus" that "a problem existed" (Lillie-Blanton, Rushing, and Ruiz 2003: 1) was reinforced by educational campaigns on "minority health" by the Kaiser Family Foundation targeted to both general<sup>429</sup> and physician audiences.<sup>430</sup> Even with the preponderance of epidemiological evidence suggesting the scope of health care disparities in the United States, the sanitization of the *National Healthcare Disparities Report* (Agency for Healthcare Research and Quality 2003) by the Bush administration<sup>431</sup> returns us to the health is not innocent theme of Chapter Two.

In February of 2004 it was reported that the Department of Health and Human Services would republish an unexpurgated version of *National Healthcare Disparities Report* that was "improperly altered." Tommy Thompson, Secretary of DHHS, said "that 'some individuals took it upon themselves' to make the report sound more positive than was justified by the data" (Pear 2004b). Professor Gregg Bloche of Georgetown University said, "The administration's report does not fabricate data, but misrepresents



the findings. It submerges evidence of profound disparities in an optimistic message about the overall excellence of the health care system" (Pear 2004b). This must be understood in the context of findings across multiple federal agencies<sup>432</sup> by the Union of Concerned Scientists that "the scope and scale of the manipulation, suppression, and misrepresentation of science by the Bush administration are unprecedented" (Union of Concerned Scientists 2004: 2).<sup>433</sup> Dr. John H. Marburger III, director of the Office of Science and Technology Policy at the White House and science adviser to President Bush, discounted the Union of Concerned Scientists report by characterizing it as an overreaction to individual acts:

...the report consisted of a largely disconnected list of events that did not make the case for a suppression of good scientific advice by the administration. "I think there are incidents where people have got their feathers ruffled," Dr. Marburger said. "But I don't think they add up to a big pattern of disrespect." "In most cases," he added, "these are not profound actions that were taken as the result of a policy. They are individual actions that are part of the normal processes within the agencies" (Glanz 2004).

This "few bad apples" rationalization for systemic behavior that is part of "normal processes" is reminiscent of Chapter Four's discussion of market fundamentalism that routinized "Enronitis" and Bush administration justifications of torture of Iraqi prisoners.<sup>434</sup> Just as the American Medical Association warned of keeping politics out of medicine in Chapter Three, defenders of the Bush administration dismissed the Union of Concerned Scientists report as "a politically motivated statement"<sup>435</sup> (Glanz 2004).

#### Disputed Destinations: Health Care as Human Right, Public Good, and Commodity

Robert Evans, a Canadian health economist, is a critic of the "steersman metaphor"<sup>436</sup> of public policy that suggests that "we are all in the same boat, and we all want to get to the same place" (1999: 27). The crux of this image of steering a boat to a shared destination is that disputes are viewed as really about means to achieve a shared

objective rather than about the ends. If the destination is improved health and functioning of all people in the United States as suggested by the Committee on Quality of Health Care in America then the current model of market medicine is an unlikely vessel:

The shared objective that people hold for their health care systems would appear to be effective health care, efficiently provided, available to all who need it, and at a reasonable cost shared equitably among citizens...If such a health care system *is* the objective that the steersman is to make for, the evidence to date is pretty clear. It must be a universal system with public funding and control, in which access to care does not depend upon ability to pay, but contribution does (Evans 1999: 27).

The inadequacy of the steersman metaphor explains for Evans the history of perpetually recycled disputes<sup>437</sup> in health care policy that are never resolved by data, experience or analysis.

Bluntly, in economic terms alone, what is good for some is bad for others. The steersman metaphor disguises this conflict, and thus misrepresents as technical debates over *means*, what are in fact political choices over *ends*. The real difficulty in steering is that we do not agree on where we want to go, and we differ on how best to get there (Evans 1999: 28).

Given the evidence of 45 million people uninsured in 2003 and substandard health care provided by "safety net" medical services to the poor (Abraham 1993; Hilfiker 1994), it seems obvious that the overriding "end" of health care in the United States is currently profit.

Treating health as a commodity may be contrasted with views of health as a human right or as a public good. The Constitution of the World Health Organization (1946) states that:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.

The Thirtieth World Health Assembly's adopted resolution WHA30.43 in May 1977 of "health for all by the year 2000" may be seen as a mechanism for advocating

health as a fundamental human right. The “health for all” (HFA) social target for governments and the WHO was elucidated as follows:

...as a minimum *all* people in *all* countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live. To attain such a level of health every individual should have access to primary health care and through it to all levels of a comprehensive health system (WHO 1981: 15)

Health as a value was to be realized through access to primary and tertiary health care.

The Alma-Ata International Conference on Primary Health Care of 1978 defined primary health care (PHC) as follows:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community (WHO 1981: 32)

Ilona Kickbush argues that this Declaration of Alma Ata was “no less than a redefinition of the norms and expectations of the state role with regard to health” (2000a: 981).

Kickbush goes on to suggest that the HFA agenda laid the foundation for much of contemporary health debate by its framing of health as a triangle of economics, politics, and human rights.<sup>438</sup> While these might be considered to be elements that cross borders and the “Global Strategy” was intended for all countries: “the reality has been that most wealthy countries have considered that PHC and HFA do not apply to themselves, if they have considered them at all” (Basch 1990: 205).

Ilona Kickbush (2000b) has suggested that “with globalization, there is no us and them anymore—it is a mixture of fear and self-interest that is leading to change.” In this view there has been a shift in international health, moving from control to development to investment regimes, to a current global health paradigm. This paradigm is closely

identified with global public goods,<sup>439</sup> which are defined as non-excludable, non-rival benefits that cut across borders, generations, and populations (Kaul, Grunberg, and Stern 1999). Global public bads are also non-excludable and so the following warning:

If the current disease burden of sub-Saharan Africa and other poor countries is allowed to persist, it could have serious repercussions for economic globalization, international peace and security, and the prosperity and well-being of industrialized countries (Kaul and Faust 2001: 870).

Health is becoming a global public good through two forces associated with globalization. Increased flows of peoples, goods, and information have accelerated disease transmission of infectious, environmental, and behavioral health risks. Secondly, increased pressures on “common-pool global resources” such as air and water have generated environmental threats that require responses that transcend national borders (Chen, Evans, and Cash 1999: 289). While this framing has implications for global health policy,<sup>440</sup> the possibilities for enlightened self-interest derived from considering health as a public good are no less cogent for people interested in local and national scopes of analysis.

The concluding point to be made with respect to considering health as a human right is to note that while this end may seem quixotic in an American context, the newest Director General of the World Health Organization has reaffirmed it as a destination. Speaking then as Director-General elect of the World Health Organization, Doctor Jong-Wook Lee, said the objective of “WHO in the New Millennium” is “to change the world by devoting ourselves to the long delayed vision of Health For All” (Lee 2003). He unequivocally went back to the WHO Constitution’s framing of “right to health” and noted “familiarity with the language dulls its moral power.” The goals of HFA2000 were not met but the “insights were sound and it has lost none of its relevance.” The tool to achieve HFA is PHC which is often misunderstood—“PHC does not mean health care on the cheap for poor people.” “HFA ideal is anchored in people’s bodies, in their flesh

and blood” and the suggested tools to obtain it include public health, medicine science, accountability, and justice (Lee 2003). While one might argue which of these tools and in what combination is more likely to be successful in accomplishing “health for all,”<sup>441</sup> the salient point to note here is how divergent this HFA destination is from a health system organized to extract profit.

The organization of this chapter which devotes most of its attention to discussing the “means” of health care systems (efficiency, quality, and equity) rather than the “ends” (health as a human right, public good, and commodity) is a simulacrum of the phenomenon under discussion. The ease with which even a student devoted to the full range of discursive approaches to health (Exhibit 2.26ghhht) defaults to a fascination with the technical aspects of a delivery system for biomedicine illustrates some of the challenges of discussing this complex, enculturated topic. This chapter does, however, set the stage for the following chapters that will examine conflicting roles of physicians as professionals, workers, and entrepreneurs as they participate in health care reform in the United States and Canada. Before moving to those chapters, however, the last section of this chapter will suggest how efficiency, quality, and equity are essential elements of health care reform discourse.

#### Efficiency, Quality, and Equity as Operational Terms of Health Care Reform

Efficiency, quality, and equity are objectives of health care systems that also do much of the symbolic work that makes reform of health care systems possible. The poetry of health care “crisis” is wonderfully ambiguous<sup>442</sup> so that all may agree that a crisis is enfolding or imminent while different constituent groups or individuals can each project the crisis to be of a different nature. The scope of a health care crisis and preferred solutions to ameliorating it will vary tremendously depending on how efficiency, quality, and equity are valued and represented.

Earlier sections of this chapter have suggested that both apocalyptic demography and escalating demands for embedded technologies could be utilized as threats to “sustainable” publicly financed health care systems thereby justifying a need for market based reforms. Previously demarcated destinations of health care as a human right or as a public good may drift towards understandings of health care as a commodity when efficiency and quality are perceived to be compromised. Conversely, systems of commodified health care may be challenged by appeals to equity grounded in the value of health care as human right and by appeals to quality and efficiency grounded in the value of health care as a public good. The Institute of Medicine, for example, called for universal health insurance coverage by 2010 as a matter of “enlightened self-interest for everyone” given the economic cost to the United States of \$65 billion to \$130 billion a year from poorer health and premature deaths of the uninsured (Pear 2004a).

A vivid illustration of a strategic representation of health care crisis in the United States may be provided by syndicated talk show host, Michael Savage, who is “the number one drive time talk show host in the San Francisco market.”<sup>443</sup> Savage is marketed as a “trained scientist” with graduate degrees in medical botany and medical anthropology and a PhD in Epidemiology and Nutrition Science from the University of California at Berkeley. His website purports that he created the phrase “compassionate conservative” in 1994 and provides extensive informational and donation opportunities for the Paul Revere Society.<sup>444</sup> Savage gives a particularly colorful account of the health care system in the United States in crisis as it slips “into a sinkhole” of “socialized medicine:”

The entire American health-care system as we’ve known it is slipping into a sinkhole from which we may never recover. If you think we have health-care problems now, just wait. If something drastic doesn’t change—and soon—I give us ten, maybe twenty years and our hospitals will be like they are in Havana, Toronto, and London.

Why is this happening?

Two reasons. First, because the culture has been under attack for thirty straight years by the radical Left who fight for the rights of the parasites. As you'll see, the Ingrates, the Inmates, and the Illegals have infected our system of health-care.

These parasites are devouring the host and must be stopped.

Secondly, the Enemy Within has set America on a slow creep toward universal health care—which is really socialized medicine. Never mind the fact socialized medicine is a flop. Everywhere it's been tried, it's been a complete failure. It's Third World medicine. Hear me. This neo-Marxist practice is the surest way to bankrupt the economy and destroy America (Savage 2004: 51).

In this diatribe the distal agent of destruction that threatens “to bankrupt the economy and destroy America” is the “radical Left” but the proximal processes are valorization of efficiency in its manifestation as cost-control and celebration of quality defined as access to technology and tertiary care. Despite evidence presented earlier in this chapter that health care systems with universal health care are less expensive and often have better population health outcomes, Savage argues that universal health care would “bankrupt America” and force “hard-working taxpayers” to “pay for someone else’s misfortune” (Savage 2004: 53). According to this rhetorical construction, “businesses will have to put their companies at risk in order to give everyone—including inmates and illegal aliens—a gold-plated medical care system” (Savage 2004: 53).

This xenophobic and racist<sup>445</sup> analysis embodies the ideology of liberalism discussed in Chapter Two of competitive individualism, property rights, and limited government. Savage has a narrow conception of quality that appeals to nationalism and a romantic view of technology without a corresponding interest in outcome measures:

It's beyond me how anybody can think a socialist-based approach to medicine is an improvement to what we have in America. Show me one country where it's a better system.

Show me where it's superior.

Show me where waits are shorter.

Show me where there's greater freedom of choice.

Show me where the doctors and surgeons are better.

Show me where the medicines are more sophisticated.

Show me where people have faster access to treatment.

You can't, because such a country doesn't exist.  
If the care is so wonderful in nations with socialized medicine, then go to Cuba for your next cardiac bypass. Fly down there. I'm sure Dr. Castro will be happy to perform surgery with his dirty smock. Dr. Castro went to medical school for maybe two years and did his internship operating on donkeys. Go ahead; take your hemorrhoids to Cuba. You'll find tenth-rated doctors with no medication on their shelves, long waiting lines, inferior surgical capabilities, and inferior diagnostic tools.  
That's what universal health-care brings (Savage 2004: 55).

This Cuban example by Savage is particularly disingenuous given the economic blockade<sup>446</sup> by the United States against Cuba that includes pharmaceutical and diagnostic supplies as well as food and chlorine for water purification (Chomsky 2000: 351-353). Although access to sophisticated treatments may be limited by the American embargo of medicines, medical supplies, and training materials, access to Cuban primary care is remarkable with a doctor and nurse team caring for approximately 100 families (Chomsky 2000: 354).<sup>447</sup> A poor person in Havana (let alone Toronto or London) might actually fare better than in Harlem<sup>448</sup> (McCord and Freeman 1994) or Chicago (Abraham 1993).

Equity is only a point of crisis for Savage to the extent that it must be resisted; those he describes as parasitic ingrates, inmates, and illegals that "have infected our system of health care" must be stopped. Dehumanizing language is used by Savage to clearly demarcate marginalized others as sources of contamination to the nation and a health care system that does not include them. The crisis in health care in this framing is not disparities in health or 45 million American uninsured or iatrogenic mortality but perceived threatened access to invasive cardiac interventions (which may not provide any survival advantage anyway) for hard-working, tax-paying, non-incarcerated, non-alien, non-them who are us. The destination or ends for health care reform in the United States for Michael Savage is market medicine for the chosen who most resemble Michael Savage. Appeals to efficiency and quality while ignoring equity are the operational terms he uses to promote his preferred version of health care reform.



Although Savage's theoretical framework and supporting evidence pertaining to health care reform are weak for reasons outlined earlier in this chapter, his rhetoric is still important because of his influence as a popular radio personality and author. Savage may be inaccurate in many of his assertions but his ideas are widely disseminated as a "trained scientist." The tag line of "Savage Nation" on his syndicated radio show and on his website is used as an umbrella to gather together those who he exhorts to protect America and as shield to repel those who do not hold his criteria for citizenship. Savage's rhetoric is part of the cultural context that informs and misinforms debate on health care reform.

While the structure of Savage's rant against universal health care insurance is instructive as it so clearly illustrates a privileging of certain health care reform objectives over others, his voice, of course, is but one of many on this perpetually timely topic. The following three chapters will revisit the professionalization and entrepreneurialization themes of Chapter Three by considering organized medicine's role in health care reform in the United States and Canada.

CHAPTER SEVEN  
"COOLERS"<sup>449</sup> OF CONSOLATION: PAYING FOR POWER WITH SUFFERING

There is a politics of health in the United States, some of the constitutive elements of which have been developed in earlier chapters of this dissertation. The following three chapters will outline and partially deconstruct the unique role that physicians play in the construction and execution of a politics of health, central to which is the kind of politics that is organized around the notion of health care reform.

If one looks at the range of factors that have an impact on the role of physicians in health care politics, a critical and central dynamic involves issues related to physicians' authority. Paul Starr defines authority as "the possession of some status, quality, or claim that compels trust or obedience" (1982: 9). Two effective sources of control that are intrinsic to authority are dependence and legitimacy. As physicians often make decisions that have consequences for life, death, and well-being for people who are in particularly vulnerable situations, there are dynamics of physical and emotional dependence in play. Legitimacy involves the willingness of subordinates to accede personal and collective sovereignty to physicians based on an acceptance "of the claim that they should obey" (Starr 1982: 10). Both dependence and legitimacy take on a special charge when an occupational group is giving advice that "one may not safely ignore" (Starr 1982: 14).

The relative success or failure of physicians in health care politics depends ultimately on the relative degree of cultural, social, and professional authority that they possess. Paul Starr suggests that cultural authority "refers to the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true" (1982: 13). This may be distinguished from social authority, which involves "the control of action through the giving of commands" (Starr 1982: 13).

Professional authority, including medical authority, is derived and defined by dependence on the “professional’s superior competence” that is legitimated by collegial, cognitive, and moral attributes (Starr 1982: 15) that are constructed by cultural authority and implemented daily in the routine practices of social authority. Possibilities generated by professional authority led to the rise of what Starr terms “a sovereign profession,” which in turn was able to accrue additional resources for agency based on economic might and political influence. Chapters 7 and 8 will focus on the manner in which physicians gain or lose cultural, social, and professional authority and detail ways in which these modalities of authority operate as an input into the discourses of health care reform in the United States.

#### Physicians as Authority Figures: Coolers of Consolation

Cultural authority commonly associated with physicians makes them ideal “coolers.” Erving Goffman’s famous metaphor of “cooling the mark out” is described below in the context of criminal fraud or the “con game:”

After the blowoff has occurred, one of the operators stays with the mark<sup>450</sup> and makes an effort to keep the anger of the mark within manageable and sensible proportions. The operator stays behind his team-mates in the capacity of what might be called a cooler and exercises upon the mark the art of consolation. An attempt is made to define the situation for the mark in a way that makes it easy for him to accept the inevitable and quietly go home. The mark is given instruction in the philosophy of taking a loss (Goffman 1952: 452).

Situations where people need to be cooled out, that is circumstances that precipitate the need for consolation, are not confined to crime scenarios. As “one theme in a very basic social story” (Goffman 1952: 453), other instances of when people might need instruction in “the philosophy of taking a loss” include the realms of customer service where institutions “cannot take it on the lam” (Goffman 1952: 455),

“decourting” as romantic relationships dissolve (Goffman 1952: 456), and disappointments in professional life such as being terminated from a job (Goffman 1952: 455-456). Physicians and priests perform the role of coolers when death is near:

Doctors must frequently help a family, and the member who is leaving it, to manage the leave-taking with tact and a minimum of emotional fuss. A priest must not so much save a soul as create one that is consistent with what is about to become of it (Goffman 1952: 457).

In these examples of managing loss on the individual and familial levels, Goffman notes that “words of consolation and redirection” seem to have “greater power to convince if they come from high places” (1952: 457). Goffman further suggests that a psychotherapist could be considered “the society’s cooler:”

His job is to pacify and reorient the disorganized person; his job is to send the patient back to an old world or a new one, and to send him back in a condition in which he can no longer cause trouble to others or can no longer make a fuss. In short, if one takes the society, and not the person as the unit, the psychotherapist has the basic task of cooling the mark out (Goffman 1952: 461).

Cultural authority is not accidental and not innocent. Chapter Three gives historical examples of physicians utilizing health, science, and professional organization as means of legitimation. An important contemporary example of how cultural authority is developed, perhaps behind a facade of presumed innocence, is through the Dr. Wellbook<sup>451</sup> collection of children’s books published by Tim Peters and Company Inc. The anthropomorphic adventures of adorable patient and family member characters that are featured in this series are illustrative of those in need of cooling while the authority of the physician characters is elucidated by reading these stories concurrently with Starr.

“The authority to interpret signs and symptoms, to diagnose health or illness, to name diseases, and to offer prognoses is the foundation of any social authority the physician can assume” (Starr 1982: 14). This interpretive function is bolstered by professional authority, which depends for its legitimacy on collegial, cognitive, and moral attributes previously mentioned that, in turn, involve three claims:

First, that the knowledge and competence of the professional have been validated by a community of his or her peers; second, that this consensually validated knowledge and competence rest on rational, scientific grounds; and third, that the professional's judgment and advice are orientated toward a set of substantive values, such as health (Starr 1982: 15)

Health care workers featured in this series<sup>452</sup> of pediatric pedagogical aids are not school health aids, school nurses, community health workers, public health nurses, nurse practitioners or physician's assistants, but consistently physicians. Even for scenarios involving routine immunizations or diagnosing colds, these beautifully illustrated stories serve only to cement a fetishized role of physician as the only significant health care worker in every possible context in the imagination of the public. Each physician plays the pivot role of interpreting and explaining what is happening to the young animal characters so that they and their parents have a language to describe their realities.

To take but one story<sup>453</sup> as an illustration, *Maxine's Vaccine*<sup>454</sup> is a charming tale of an introverted bunny who has a barnyard adventure, which leads to Dr. Gruff's moral that "getting vaccinated on schedule is the best way to keep a little bunny healthy" (Peters 1994: 13). A darker reading, however, might notice that the consequence of Maxine not wanting to visit the doctor and of neglecting to stay close by her family unit is abandonment and danger. Maxine's mother does not notice that Maxine is hiding in the garden and so Maxine is left all alone. Maxine is nearly discovered by Farmer Green; does Farmer Green live in Flint, Michigan with the Bunny Lady selling rabbits "For Pets or Meat"? (Moore 1989). Buttermilk the Cow (milk or beef?) and Robbie Rooster (fertilizing eggs or chicken dinner?) both urge Maxine to get with the vaccine program while Tiger, the barn cat, gazes at Maxine as a snack. Despite the fact that she is taking health advice from comestibles and just escaped being eaten herself due to her non-

compliance, Maxine says “today I learned my lesson that vaccines help keep you healthy” (Peters 1994: 12).

A different lesson that Maxine might have learned is that her mother, who did not notice that Maxine was missing on the journey to the doctor with her other bunnies, was scamming her. Maxine’s mother had told her, “we’re going to visit the doctor to discuss the role of vaccines” (Peters 1994: 1). Dr. Gruff’s plan, however, was to give Maxine vaccines “today, and in later visits” against “hepatitis B, diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, and *haemophilus influenzae* type b” (Peters 1994: 13). If Maxine is considered the mark in a play to get her vaccinated against her wishes, her mother, Buttermilk, Robbie, and even Tiger all might be considered steerers. Dr. Gruff, in this example, is the cooler with cultural authority to define reality. His professional authority is symbolized by his diploma that verifies legitimation by his peers, his white coat and stethoscope that signals his scientifically grounded competence, and his orientation to the value of health expressed in his speech.<sup>455</sup> As a cooler, Dr. Gruff helps Maxine accept the inevitability that she will be vaccinated for her own good in the context of a meta-narrative of comply or die.

#### Political Uses of Cultural Myths: From “Sovereign Profession” to “Ethical Businessman”

Starr’s landmark history of American medical care and the role of physicians, *The Social Transformation of American Medicine*, underscores the point that cultural, social, and professional authority are somehow always in the service of the economic status of the physician and the social status that he or she seeks to gain from it. From an economic point of view then, health care reform, in most of its elements, is about how much money flows into the health care sector, how it is apportioned, and of critical importance to physicians, what fraction goes to physicians, and under what organizational form.

Starr documents the historical movement from the physician as an actor of ambivalent and uncertain social status to one of an importantly statused individual entrepreneur able to make unchallenged assignments in the market for his or her services. Familiarly then, in the United States, the passage of Medicare and Medicaid, although opposed by organized medicine for reasons of not wanting to accept external control, turns out to be an enormous boon to the profession in terms of directing vast amounts of public funds into health care. This legislation thus allows all health care costs to rise, physicians' incomes included. So in some critical way, health care reform is, at the heart of it, about controlling the amount and distribution of this income. Not surprisingly, physicians' roles in health care reform are then characteristically associated with this complex of forces. These movements for economic positioning require some rhetorical deftness given that they often play hard against other parts of the ethical calculus of the physician. Historical examples of this rhetoric suffuse Chapters Three (especially Exhibits 3.5 and 3.6) and Five while contemporary illustrations will be featured in this and subsequent chapters.

Eminent health economists have long reminded us that "national health care expenditures = national health care income" (Reinhardt 1982: 16) and "every dollar of expenditure is a dollar of someone's income" (Evans 1999: 35).<sup>456</sup> Physicians have an extraordinary role to play with respect to health care expenditures/health care incomes in that it is their clinical decisions that determine usage of diagnostic tests, surgical and medical treatments including pharmaceuticals, need for hospitalization, specialists referrals, and follow up care. Doctors both provide and manage care; "although physicians' fees represent only about 20 percent of health care costs, as much as 80 percent of expenditures for medical care are for services prescribed by physicians" (Eisenberg 1986: 3).<sup>457</sup> For this very reason, the most persuasive rationale for celebrating the invasion of Grenada by the United States, it has been convincingly argued in "Cost

Containment by Naval Armada,” was the closure of St. George’s Medical School. The estimated cost to society of each physician in practice (for income, overhead, hospital care, drugs, and amortization of capital costs) was \$450,000 per annum (Maloney and Reemtsma 1985: 1713).<sup>458</sup> While a specific figure to update this \$450,000 per year is difficult to find, recommendations of the Council on Graduate Medical Education<sup>459</sup> on goals for a national physician workforce arise from an historical understanding that “physician supply excess was considered a contributing factor to increases in health care costs that were not accompanied by improvements in the health of the public at large” (2002: 4).

Two decades after John Eisenberg’s *Doctors’ Decisions and the Cost of Medical Care*, concerns about practice patterns continue to be reflected in research about the effectiveness and cost of physicians’ clinical decisions in the medical literature. A contemporary illustration suggests that even among hospitals with reputations for excellence, care for Medicare patients during the last six months of life can vary dramatically. For example, patient cohorts loyal to New York University had, on average, 76 physician visits, with 57% seeing 10 or more physicians and spending an average of 27.1 days in hospital. This may be compared with patient cohorts loyal to the University of California Medical Center in San Francisco who had, on average, 27 physician visits, with 30% seeing 10 or more physicians, and spending an average of 11.5 days in the hospital (Wennberg et al. 2004). Authors of this study<sup>460</sup> point to a direct relation between supply of services (physicians and hospital beds) and utilization. A study of regional differences in Medicare spending<sup>461</sup> found that patients in regions with higher spending received 60% more care although the cohort members were similar in baseline health status. Mortality was between 2% and 5% higher in higher spending regions which these researchers attribute to increased exposure to risk of medical errors with greater use of hospitals and specialist care (Fisher et al. 2003). The former study



supports “Roemer’s Law”<sup>462</sup> of supply pushing demand while the latter study supports the observation that more medical care does not necessarily correspond to better health outcomes.

Deborah Stone makes a compelling argument that until the late 1970’s, physicians fought hard individually and collectively to protect their entrepreneurial interests (examples of which may be found in earlier chapters of this dissertation), even as the “moral norm that justified their autonomy from state regulation was a strict separation of clinical judgment and pecuniary interests” (1997a: 533). Although financial incentives have long been an actual part of healing, the cultural construction of scientific, professional medicine was that decisions made by physicians were always determined by the best interests of the patient. This “public story” changed with the onset of managed care which theorized that medical decisions should be based on “economic consequences for society” as well as clinical criteria (Stone 1997a: 542). From the “ideal of the doctor as free of commercial influence” there is “now, the opposite idea—the image of the doctor as ethical businessman whose financial incentives and professional calling mesh perfectly” (Stone 1997a: 552). The iconography or what Stone calls “the political uses of cultural myths” (Stone 1997a: 534) of the doctor as ethical businessman has an appeal for some physicians as it conveys some measure of independence in a context of eroding clinical autonomy and “it acknowledges that they need and want to make money in a way that the old ethical codes didn’t” (Stone 1997a: 552).

This recoding of physicians as “ethical businessmen” arises as loss of autonomy, income, and deskilling have caused some to wonder if physicians are being deprofessionalized (Haug 1988) or even proletarianized (McKinlay and Arches 1985). These latter two characterizations are a marked departure from traditional theories of professional dominance that are associated most commonly with Elliot Freidson (1970; 1988).<sup>463</sup> It is important to recall that the glory days of medicine as a “sovereign

profession" (Starr 1982) are also associated with what James Robinson has called the "medical arms race" that provoked the Health Maintenance Organization Act of 1973 in the first place:

The framework of medical professionalism created a spiral of expanding capacity, technology, utilization, and cost....The Achilles' heel of the professional system was the lack of financial controls. Physicians and hospitals were motivated to provide ever more and better services, since higher costs generated higher revenues. Patients were motivated to demand more and better services since the costs were shifted unto insurers and thence to employers and taxpayers (Robinson 1999: 23).

This spiral of escalating costs provoked a series of events, each termed a "crisis," that in turn seemed to generate a new set of challenges. Or, as former U.S. Surgeon General Dr. C. Everett Koop argued, "Health care reform is a never-ending problem. Each solution becomes a problem" (Kaiser Daily Health Policy Report 2002).

#### Physician Identity and Health Care Reform

An essential element to doctors' moral authority,<sup>464</sup> which is encapsulated into the social, cultural, and professional authority of physicians, has always come from the notion that physicians have a unique role in society as important brokers, arbiters, witnesses, priests, helpmates, and healers as people make the journey between life and death. Secondly, the passage into the guild is literally a rite of passage where only the best and brightest are heralded to survive. Coupled with the normal gatekeeping functions of MCATs and other initiations that will be discussed directly, the reality has been a physician is asked to engage in a work-life that may not be unique<sup>465</sup> in terms of its range of demands and commitment but is certainly special enough. This constellation of demands and commitments leads to a powerful sense of professional bounding between individuals and the rest of society. This isolation then produces what might be called physician identity. The following section will consider how physician identity and its possibilities for power are generated by a cruel socialization

process that justifies its excesses as needful<sup>466</sup> for the installation of physicians' authority. This punishing socialization ritual has implications not only for the well being of physicians but also for patients as doctors' capacities for compassion are depleted and imaginations that might foster social solidarity turn instead to mocking those who are less privileged. While individuals' triumphs and frailties are celebrated or denigrated as choices, the latter part of this sub-section will consider how structural components of this socialization process create conditions of possibility by citing illustrations of "gaming the system" and "forced choices" attributed to debt.

#### Creating Doctors: Paying for Power with Suffering

A central feature in the experience of many students of medicine has been described as "academic trauma" (Becker et al. 1961: 105) and as "the culture of student abuse in medical school"<sup>467</sup> (Kassebaum and Cutler 1998: 1149). Traumatic experiences<sup>468</sup> that are caused by and exacerbated by an overwhelming workload, physical and emotional exhaustion, and inadequate institutional support are a routine narrative thread in personal accounts of medical school (Klass 1987; Rothman 1999). In this context of being highly scrutinized, heavily subordinated, and often poorly supported, medical students are not without autonomy and power. As members of a "community of fate,"<sup>469</sup> medical students "tend to have considerably more power to determine the conditions of their existence and actions than the authority system of the organization formally allows and that they use this autonomy to develop systems of belief and action that may run counter to those their superiors desire" (Becker et al. 1961: 362).

Some of the resistance tactics that medical students<sup>470</sup> and house officers may develop to a training regime that is often intolerable have implications for patient care. A consideration of the use of slang language and gaming behavior by physicians-in-training suggests an instrumentalization of patients that might exactly "run counter" to

the aspirations of their mentors. An introductory qualification to this discussion is that shared understandings and perspectives of the medical profession are informed by the norms of the larger cultural context. Medical students<sup>471</sup> at the University of Kansas at the time of Howard Becker and his colleagues' study, for example, were working in segregated hospitals; as they were not allowed to deliver white women, all their clinical obstetrical experience "came from the delivery of Negro women" (Becker et al. 1961: 214). The taken-for-granted aspects of racial segregation and relative value of who was an appropriate body for teaching fodder were intertwined with an atmosphere of disdain for low-income patients. As one medical student, Craig, said, "you'll never catch me doing any charity work...The way I feel is if they can't pay for it they don't deserve to get it" <sup>472</sup> (Becker et al. 1961: 319).

While "the core drama of medicine" may be "the treatment of diseased human beings" (Becker et al. 1961: 186), the core drama of a medical student is meeting his or her learning objectives. Charity patients historically provided students the opportunity to practice skills that are off-limits on private patients but ambivalence remained. "Students dislike charity patients, who are likely to be, they feel, unable to give an intelligible history; charity patients are, in simple antithesis, 'unintelligent' or 'dumb' (Becker et al. 1961: 335). Students resented and continue to resent patients who cannot articulate an intelligible history because ambiguity heightens their risk of humiliation when medical preceptors interrogate them in a process now commonly known as "pimping."<sup>473</sup> This consuming desire to learn incessantly or just to meet minimal learning objectives may collide with the needs of "uninteresting" patients seeking cure and care.

The power of the subaltern then arises in diction as frustration erupts against patients who waste time by not being clinically significant. A person presenting with psychosomatic symptoms may then be called a "crock" signifying "a patient with vague

and untreated psychosocial complaints, but not discernable pathology” (Becker et al. 1961: 304). Professor of anthropology and physician, Melvin Konner, notes in a glossary of house officer slang that *crock* “appears to be short for ‘crock of shit,’ but the latter full phrasing is never heard” (Konner 1987: 382). The treatment of *crocks* is “psychoceramic medicine” which “ridicules a category of patients and a category of physicians (including the whole profession of psychiatry) simultaneously” (Konner 1987: 387).

Language is “the most important tool in medicine” (Coombs et al. 1993: 987). When wielded by house officers, these tools are significant because this language “expresses their unique world view—their concepts, their categories, their defenses, their humor” (Konner 1987: 379). Interviews with 30 clinicians<sup>474</sup> suggest that the use of medical slang<sup>475</sup> provides five important functions. “Slang: 1) creates a sense of belonging in a select inside group, 2) establishes a unique identity, 3) provides a private means of communication, 4) is an exercise in creativity, humor and wit, and 5) softens tragedy and discharges strong emotions” (Coombs et al. 1993: 992-993).

It is thus not surprising that those who are physically and emotionally exhausted, and who are overwhelmed with a Sisyphean workload, which oscillates between moments of life-and-death import and mind-numbing “scut,”<sup>476</sup> may occasionally express passive-aggressive or aggressive-aggressive feelings in their language. This comes out in such charting abbreviations as A.M.F. (Adios Mother Fucker) (Konner 1987: 380) and Solomf yoyo (So long mother fucker, you’re on your own) (Fox et al. 2003: 187) or exhortations such as TTFO (told to fuck off) (Fox et al. 2003: 188) or treatment plans such as PRATFO (patient reassured and told to fuck off) (Fox et al. 2003: 187). The outlet of slang is said to translate “human tragedy into human comedy” (Coombs et al. 1993: 996). As a “safety valve” for “letting off steam,” one resident physician interviewed said, “If we use the slang terms, we don’t take out our anxiety and stress on our patients as much” (Coombs et al. 1993: 996). While some may

argue, “hospital slang for patients does not express insensitivity or lack of concern for patients,” an interviewed clinician said, “I’ve never heard the word ‘gomer’<sup>477</sup> used in a non-derogatory way. It may be said in jest, but it carries that subtle message that a patient is less than a salvageable human being” (Coombs et al. 1993: 995).

“Turfing”<sup>478</sup> is a colloquial verb often used by house officers that “denotes the transfer or triage of a patient from one physician to another when the care of that patient feels to be more trouble than it is worth” (Caldicott, Dunn, and Frankel In press: 1). A qualitative study designed “to reveal aspects of the ideology of internal medicine” through an examination of the language of turfing notes an underlying premise that “the individual doctor or service becomes a territory” (Stern and Caldicott 1999: 243). Encroachments by unwanted patients are resented and are deemed to be “inappropriate” (and thereby turfs) when the receiving physician cannot provide a more effective therapy than the transferring physician. Receiving physicians may experience turfed patients as disruptive, time consuming and inconvenient; not coincidentally, they often concurrently judge the behavior of physicians making the transfer to be self-serving and medically unwise for disrupting the continuity of care for these ricocheting patients (Stern and Caldicott 1999: 244). “Residents express frustration and anger about their lack of power on the receiving end of a turf” (Stern and Caldicott 1999: 245). As a function of the “inverse relation between authority and workload” endemic to residency training and due to “perceived interdepartmental cultural and philosophical difference,”<sup>479</sup> “turfing causes medical residents to feel used” both by those with greater authority and by residents from other services (Stern and Caldicott 1999: 245).

Three salient points about turfing are important for the purposes of the argument in this chapter: 1) gamesmanship is used as a coping device; 2) emotions generated by being subordinated are often displaced unto the patients; and 3) patients know when they are unwanted as turfs. As the buff and turf verbs suggest in the footnotes, the

language of sports and games is used as a way to describe and manage that which is unacceptable. In response to an observation from a focus group facilitator that the topic of turfing seemed to generate smiles from the participants, one resident said, "Well, you smile, I guess, because it's a game, because it's so sad, really...if you didn't laugh, make it a game, you couldn't do it" (Stern and Caldicott 1999: 246). David Stern and Catherine Caldicott (1999: 247) provide a revealing response as they wonder "why the *patient* is called a turf and not the transferring physician" and "why the residents don't label the actor with the action:"

Residents feel dominated by the turfer and repress uttering their emotional critiques directly to the turfer. Outside the presence of the transferring physician, they can voice their anger at his or her behavior in a non-threatening, face-saving way. Behind the turfer's back, the residents direct their dissatisfactions to other, less powerful persons, such as patients. Thus, when residents are in a subordinate position and powerless to refuse a transfer, they express their frustration and criticism in a way that allows them to maintain their own sense of power and control.

The consequences for patients who are turfed have not been well studied. An exploratory, qualitative study asked whether patients who were turfed might experience their hospitalization differently than those whose admissions are viewed more favorably by their physicians. In this small sample of 26 patients interviewed at a tertiary care university hospital, there were 16 coded as appropriate for their service, 8 coded as turfs, and 2 coded as equivocally (Caldicott, Dunn, and Frankel In press: 3). Preliminary evidence suggests that although both the appropriate/equivocal and turf groups articulated complaints, especially about poor doctor-patient communication, the turf group's experiences were so negative "that they eclipse whatever positive experiences might have occurred (Caldicott, Dunn, and Frankel In press: 5). Paraphrasing W. I. Thomas, Cadicott, Dunn, and Frankel (In press: 6) summarize, "If a resident believes a patient to have been "turfed" to his or her service, that belief will be real in its consequences."

What happens then at the intersection between overwhelmed medical labor working in health care systems under strain when they encounter people considered to be detritus in popular culture? Clientele described as charity cases in Becker's research are now often considered to be "dirtballs." A dirtball is "a chronic alcoholic, drug abuser, bag lady, or other street person who rarely bathes, has frequent infectious contacts, and is likely to be a walking colony of dangerous microorganisms; a very common emergency room usage" (Konner 1987: 382). These sensibilities are given a patina of scientific quantification in British hospitals with the DBI (dirt bag index, which is calculated by the number of tattoos multiplied by number of missing teeth, to estimate days without a bath) (Fox et al. 2003: 183). The language of dirtballs, dirt bags, scumbags, slime dogs, and other disparaging terms<sup>480</sup> for low-income, low-status people in an era of increasing disparities of income, wealth, and social kinds of capital is not innocent or insignificant.

While the risks of dehumanizing both the house officers and the patients by this arduous training process seem clear, there is also a pertinent argument to consider that maintains that it is exactly this sleeplessness and stress that makes a doctor. In this view, people "must be temporarily rendered abnormal" because "no normal person can assume such responsibility, do such bizarre things to people, inflict such pain, make such heavy decisions" (Konner 1987: 373). This arduous socialization process makes doing medicine reflexive so that "you have learned to bypass existential moralizing with a grotesque pragmatic reality" (Konner 1987: 373).<sup>481</sup> The alienation between physician and patient in this socialization process is such that "in a real sense the patient becomes the enemy" (Konner 1987: 373). This statement is supported by the following analysis of medical talk by a Harvard medical student:

I picked up not only the specific expressions but also the patterns of speech and the grammatical conventions; for example, you never say that a patient's blood pressure fell or that his cardiac enzymes rose. Instead,



the patient is always the subject of the verb: "He dropped his pressure." "He bumped his enzymes." This sort of construction probably reflects the profound irritation of the intern when the nurses come in the middle of the night to say that Mr. Dickinson has disturbingly low blood pressure. "Oh, he's gonna hurt me bad tonight," the intern might say, inevitably angry at Mr. Dickinson for dropping his pressure and creating a problem. When chemotherapy fails to cure Mrs. Bacon's cancer, what we say is, "Mrs. Bacon failed chemotherapy" (Klass 1987: 72-73).

Using the language of a market transaction, Konner consoles his readers by arguing that training hardships are intrinsic and inevitable to the process of becoming a physician:

In the end, we all—doctors, patients, hospital staff—have a sense that the doctors are doctors, and can be allowed to do what they do, *because of* the rigors of the training. Because we view it as painful, stressful, life-distorting, and terribly long, we allow it to justify the remarkable power we give the doctor over us. The doctor has paid for the power with suffering (Konner 1987: 373).

If we remain within the metaphor of payment for power, in this socialization process the currency of suffering, as we have seen, is not only extracted from the doctor. Exhausted, overworked, stressed learners in a context of being often under-supervised as they "see one, do one, teach one"<sup>482</sup> and over-scrutinized by sharks during pimping, is an invitation for iatrogenic mishap as well suboptimal therapeutic rapport. The unexpected death of 18 year old Libby Zion under the care of a resident and intern in 1984, for example, resulted in a grand jury report that was "in effect, an indictment of American graduate education" (Asch and Parker 1997: 239) as well as a catastrophic event for Libby and her family.<sup>483</sup> Medical errors can and do happen everywhere, initiated by any level of health care worker and sustained by any patient irrespective of status and income. The predictable nature of iatrogenesis in any university hospital,<sup>484</sup> which needs to be coped with as regularly occurring events, is facilitated by descriptive medical slang in the house officers' toolbox, such as "electrolyte heaven" and "horror show"<sup>485</sup> that mark medical errors as routine. The point here is that the socialization of physicians,

cooler language to console trainees during episodes of disappointment, and quality of care for patients are intertwined socially constructed phenomena.

As “gaming the system” is a theme that will be reconsidered in Chapter Eight, it might be mentioned at this point that bending, breaking, or fudging the rules is not an uncommon response for people who believe themselves to be in an untenable situation. Medical students who perceived themselves “at the mercy of a capricious and unpredictable faculty” are concerned with giving an optimal impression of their abilities and knowledge “however this impression be made” (Becker et al. 1961: 292). Impression management within a system believed to be arbitrary may lead people to circumvent procedures by such games as “eyeballing” a patient’s blood test,<sup>486</sup> faking physical findings,<sup>487</sup> or misrepresenting publications on residency<sup>488</sup> and fellowship<sup>489</sup> applications. A survey sent to all accredited family practice residency directors<sup>490</sup> in the United States found 73 of 150 directors (48.6%) reported a total of 602 cases of deception<sup>491</sup> in the previous five years (Grover, Dharamshi, and Goveja 2001: 443). Given that “most directors accept application information at face value,” each director verified on average only three items (Grover, Dharamshi, and Goveja 2001: 444), and that only 2 of 16 cases of misrepresentation of publications by gastroenterology fellowship applicants were recognized at first glance, and only then because the deceptions were poorly executed,<sup>492</sup> misrepresentations might be under recognized.

At one level, as a physician with the American Board of Internal Medicine<sup>493</sup> who editorialized on the Sekas and Hutson (1995) article argues, misrepresentation has the potential to harm patients, be destructive to the ethical principles of the medical profession, and undermine the public's trust in physicians (Kimball 1995: 58). At another level, a rather convincing case may be made for the ironic nature of a medical profession that “advocates honesty but has institutionalized dishonesty” (Young 1997: 221). In “Teaching Medical Students to Lie,” Tara Young makes a compelling argument that the

structure of the residency matching program combined with vigorous competition make it necessary for residents to tailor a variety of applications to different specialties and different programs all with a convincing presentation that each is the applicant's authentic first choice specialty and program.<sup>494</sup> "When considering the use of deception in the resident-selection process, students feel coerced into lying so that they won't jeopardize their future career" (Young 1997: 220). Young states that "dishonesty in the application process has been universally and unequivocally accepted" as students are taught that "obtaining a residency position is a competitive venture in which the truth not only can but also must be compromised" (Young 1997: 221). The concern that residency applicants have about telling the truth within this selection process is well founded in that "most program directors (83%) indicated that the knowledge of an applicant interviewing in more than one specialty had a (negative effect) on the applicant's rank order during the National Residency Matching Program (Grover, Dharamshi, and Goveja 2001: 444).

Given the structural nature of this dilemma, it is then interesting to note that in the "why do some candidates lie" discussion section, that the onus is placed back on each individual. "Choosing to be completely honest and forthright is a moral dilemma that must be faced by each candidate" (Grover, Dharamshi, and Goveja 2001: 445). While explicitly acknowledging Young's argument that "dishonesty has become institutionalized into our system of recruiting for postgraduate training" and that "applicants perceive that programs engage in questionable ethical practices during the recruitment period," the take-home recommendations remain individualistic in nature such as primary source verification and improved screening of applicants (Grover, Dharamshi, and Goveja 2001: 445). An examination of the assumptions inherent in residency matching systems is not entertained by the educators but is posed by a student. "When today's students are physicians, will they be more or less likely to tell

the truth after having learned how to lie to their advantage during the resident-selection process?" (Young 1997: 221). The structural nature of "teaching medical students to lie" is all the more fascinating to consider when read conjointly with a study documenting misrepresentation by applicants for medical school faculty positions, which also demonstrates many of these elements of individualistic analysis and cognitive dissonance not fully articulated.<sup>495</sup>

A final consideration before moving to the next section is to note that financial debt accrued in the course of becoming a physician contributes both to stress on individual physicians and to "forced choices" in practice patterns. The average debt<sup>496</sup> that a medical student incurred over four years in the United States was \$80,462 in the mid-1990's (Naradzay 1998) and up to almost \$104,000 in 2002.<sup>497</sup> This high debt burden is then given on the American Medical Association's website as a rationale for selecting specialties, geographic areas, and practice settings that provide higher remuneration. "Consequences" of this cycle include "the shortage of primary care doctors" and a need to "shun working in public hospitals and in geographic areas where their income will be insufficient to allow payment of student loan debt."<sup>498</sup>

### Physicians' Well Being: Suicide, SARS, and Unforgivable Gazes

The well being of physicians is both an intrinsic and an instrumental concern. While physicians may be many things, they are also human beings who are vulnerable to a range of frailties, of which some are uniquely associated with their occupation. Suicide, SARS, and the potential destructiveness of a clinical gaze that becomes habitual are used in this section as ways of exploring sacrifices that physicians make in pursuit of their professional identities as they accrue authority in their careers. It is helpful to keep in mind when reading this section both the extent to which this non-system of health

care often does not function well even for those at the apex, and the extent to which physicians' lack of well being has a cascade effect on the experiences of patients and coworkers.

A study<sup>499</sup> using data from the National Occupational Mortality Surveillance database to examine deaths that occurred in 28 states between 1984 and 1995 found that both black and white male physicians had a higher mean age of death than lawyers, all examined professionals, and all men as shown in Table 7.1 (Frank, Biola, and Burnett 2000: 155).

**Table 7.1 Mean Age of Death (for men dying after age 25 years) for Deaths Occurring in 1984-1995 in 28 States Using National Occupational Mortality Surveillance Data\***

Occupation	Mean Age at Death, Black Men	Mean Age at Death, White Men
Physicians	68.7	73.0
Lawyers	62.0	72.3
All professionals	65.3	70.9
All deaths	63.6	70.3

\*Source: (Frank, Biola, and Burnett 2000: 155-156)

White, male physicians were less likely to die from chronic obstructive pulmonary disease, pneumonia/influenza, and liver disease but more likely to die from cerebrovascular disease, accidents, and suicides than were other professional white men (Frank, Biola, and Burnett 2000: 157). This increased risk of suicide among the white, male physician cohort is congruent with findings of consistently elevated suicide rates among physicians regardless of the countries studied (Arnetz 2001: 204).<sup>500</sup> Historically, suicide has accounted for 35% of premature physician deaths, and 3% and 6.5% of male and female physician deaths respectively in the United States (Frank and Dingle 1999: 1887). Although the magnitude of suicide risk among women physicians is controversial due to small sample sizes (Frank and Dingle 1999: 1888), a systematic review of the literature found an estimated relative risk that varied from 1.1 to 3.4 in

male doctors, and from 2.5 to 5.7 in female doctors as compared with the general population (Lindeman et al. 1996).

The summary conclusion of this “first national study to examine age of death and causes of death for U.S. physicians” (Frank, Biola, and Burnett 2000: 157) states:

Our findings should help to erase the myth of the unhealthy doctor; physicians seem not to be the “ideal targets” for pathology and ill health that some have claimed. Because physicians who have healthy personal habits are more likely to talk to their patients about prevention, our results should encourage those promoting prevention and give comfort to those who hope that their physicians practice what they preach (Frank, Biola, and Burnett 2000: 159).

Although the authors mention in passing “the healthy worker effect” and physicians’ higher socioeconomic status (Frank, Biola, and Burnett 2000: 158), it is clear that their preferred model for health causation is individual lifestyle choice. As the concluding line of their abstract summarizes, “at least for men, mortality outcomes suggest physicians make healthy personal choices” (Frank, Biola, and Burnett 2000: 155).

This superficial explanation of why physicians have better mortality outcomes trivializes what population health literature (Evans, Barer, and Marmor 1994; Wilkinson and Marmot 2003) suggests is a very complex phenomenon. This reification of individual causation and agency through individualistic behavior change in their conclusion may be juxtaposed with their evidence of mortality mediated by race/ethnicity. “Healthy personal choices” seems an inadequate attribution when considering the large discrepancies between black and white men—inequities that are further increased by class, which are coded as occupational stratum. Without engaging into alternative possibilities that might be more satisfactory as explanatory frameworks, it is sufficient to point out here a preference for a reductionist, segmented discursive approach to health which in turn has its own implications for physicians’ identity.

As an alternative to superior individual self-care to explain dynamics associated with physicians’ health, there is the proposition that “physicians have better intrinsic

physical and mental health but live under higher stress<sup>501</sup> and get less routine preventative care" (Mansky 1999: 107). Jenny Firth-Cozens, for example, considers stress, depression, and alcohol use as she followed 314 medical students for 11 years in England. "There is growing evidence that doctors look after themselves very badly in terms of seeking help" and go to work when unfit, self-prescribe medications (both therapeutic and recreational), and often have no family doctor of their own (Firth-Cozens 2001: 216). Bengt Arnetz writing on the psychosocial challenges facing physicians in Sweden points to the "the well known triple sign" of the "ignorance, indifference, and carelessness" of physicians toward their own health (2001: 204). At the very least, there is strong evidence to suggest that the ability to practice what one preaches is not determined solely by one's education or intelligence.<sup>502</sup>

Important consequences of physician stress are "emotional withdrawal, social isolation, burnout, unhappiness, depression, denial of professional problems, irony, and cynicism" (Arnetz 2001: 206). These manifestations of stress (with the possible exception of irony) have negative implications for optimal patient care as well as for the personal well-being of physicians. A salient example of this is clinical depression with symptoms of memory loss, concentration deficits, selective attention, poor decision-making, irritability and interpersonal difficulties that may hinder the practice of medicine (Firth-Cozens 2001: 217). Reiterating themes discussed earlier with respect to medical socialization, Jenny Firth-Cozen (2001: 217) explicitly links the context of "the risky, competitive and occasionally humiliating medical work culture" with observations arising from her longitudinal study that an individual penchant for strong self-criticism was a strong predictor of subsequent stress and depression. Burned out physicians, often described as "angry, irritable, and impatient," are associated with decreased productivity as well as deteriorating physician-patient relationships (Linzer et al. 2001:

170).<sup>503</sup> It is also pertinent to note that the inclusion of irony as a symptom of stress is a reminder that one person's pathology can be another person's treatment.

While the suggestion that psychiatric illness may be an occupational health hazard for physicians is controversial (North and Ryall 1997), other potential dangers associated with the practice of medicine include exposure to toxic chemicals and radioactive substances, workplace violence, motor vehicular and air ambulance accidents associated with medievacs, ergonomic injuries, and exposure to infectious biological agents. Anxiety, ambivalence, and anger associated with the last factor may be illustrated by controversies generated by perceived risks associated with treating people infected with HIV. In a thoughtful essay entitled "AIDS and Its Impact on Medical Work: The Culture and Politics of the Shop Floor," Charles Bosk and Joel Frader suggest that AIDS may be seen as "a total social phenomenon acting as a vehicle for debating and defining standards of professional conduct" (1990: 226).<sup>504</sup> In addition to the stress for healthcare workers unconvinced by the efficacy of universal precautions or anxious because of a needle stick injury, Bosk and Frader (1990: 230) point out that the already stigmatized patients of "America's medical underclass" are likely to have their marginal utility as teaching objects overridden by fear of contagion thereby further compromising the care they receive from medical trainees.<sup>505</sup>

Although in the new millennium "comparative questions have not been asked recently," 21% of doctors polled in February 1991 believed in "a doctor's right to refuse to treat a patient suffering from AIDS" (Kaiser Health Poll Report 2002). Daniel Bruner, associate director for litigation and advocacy at the Whitman-Walker Clinic Legal Services, notes that some HIV positive patients remain reluctant to disclose their HIV status to physicians for conditions unrelated to HIV "because they have encountered discrimination in the past" (Albert 2002). This point came up in the context of an interview organized around reminding physicians that behavior that is equivalent to



turfing is illegal<sup>506</sup> according to antidiscrimination laws; “concern about the risk of contracting HIV from the patient is not a legitimate basis for referring a patient or denying treatment” (Albert 2002). The fact that many patients with HIV continue to experience discriminatory behavior by some physicians two decades into the pandemic suggests that the quality of care that patients receive may be contingent on slippages between individual moral and religious worldviews, refusal to treat “rights” based on market norms, human frailties, and professional code of ethics.

While people with HIV/ AIDS are still living with stigma in 2004, health care workers can console themselves at the cognitive level with the knowledge that this blood borne virus is not easily transmitted. What about when a breath<sup>507</sup> or a touch<sup>508</sup> can cause death? It is indeed difficult to know if we would have acted any differently if wearing the same lab coat as health care workers fleeing the pneumonic plague in Surat, India<sup>509</sup> or hiding at home in Vietnam or Hong Kong in response to severe acute respiratory syndrome (SARS)<sup>510</sup> or working in mortal fear from Ebola in Kikwit, Zaire.<sup>511</sup> The metaphor of “the world really just is one village” (Garrett 1994: 619) became reality for health care workers in Toronto in 2003 as they found themselves trying to sort out these same kind of competing responsibilities to self, loved ones, patients, and the common weal:

Dr Bruton said he observed different responses to SARS among his colleagues. Some doctors declined to examine patients suspected of SARS. Some doctors move to the opposite side of the room when colleagues who have cared for SARS patients are present. Some who appear to be outstanding and fearless in their usual work in the hospital suddenly collapse (sic) in the SARS outbreak because they were worried about becoming infected or infecting their families, he said. One radiologist in Toronto isolated himself in his office and interpreted X-ray films only if they were slipped under the closed door (Altman 2003b).

Physicians are additionally in the unwelcome circumstances of knowing too well how fragile the human body can be and how limited therapies sometimes are in their effectiveness. This is all the more pertinent when a physician finds himself on the other

side of the stethoscope. Dr. Mark Cheung, an internist at Sunnybrook Hospital in Toronto, contracted SARS after caring for two critically ill SARS patients. Cheung describes the following exchange with Peter Webster, a senior respirologist who arrived to care for him after Cheung was hospitalized:

Peter and I had an almost surreal academic discussion about why I was doing so poorly despite a paucity of objective findings to explain the deterioration in my condition. We agreed that my lungs were simply too stiff, and he noted that I exhibited the sign of tracheal tugging.

I was becoming irrational and panicky, even asking if a transfer to another hospital might help. Peter calmly reassured me and called an infectious disease consultant at another hospital. We all talked over the telephone about what could be done, but there was little evidence to guide us. I felt lost and despondent (Cheung 2003: 1285).

Not being permitted and/or perhaps not permitting himself to be a patient, even when in respiratory distress, is a hazard not shared by all occupations.

In addition to risks presented by overwork, emotional exhaustion, infectious agents, noxious substances, agitated members of the public, and burned out colleagues, perhaps it is the loss of personal identity and self that is a most grievous cause of suffering for some physicians. Medical student, Perri Klass, complains of a loss of kindness and personal integrity below while others have voiced similar complaints about medical training smashing ideals and taking away “your niceness as a person.”<sup>512</sup>

One of the sad effects of my clinical training was that I think I generally became a more impatient, unpleasant person. Time was precious, sleep was often insufficient, and in the interests of my evaluations, I had to treat all kinds of turkeys with profound respect (Klass 1987: 58).

If “people become what we do” (Casey 1995: 81), the being is not erased once the shift is over. If police officers often abandon trust as the currency they pay for their work, what are the losses that must be endured for the profession of medicine? One physician describes his payment for power in this kind of suffering:

Too often I find that my eyes, of their own accord, weigh the medical risk factors of people I am with. I find myself looking with Twain’s cold and critical disillusionment—the very antithesis of looking with warm love. Bitterness, sourness, supercilious distaste—these are the hallmarks of

one's face when looking to find fault. Strangers will coldly turn away and friends will feel hurt. Lovers can find such looks unforgivable (Burch 2001: 1826).

### Doing Well but Feeling Worse:<sup>513</sup> Physicians as Highly Compensated but Losing Privileges

Having considered some of the rigors of the socialization process to become a physician and some of the occupational hazards associated with medicine as a way of life, this section considers financial rewards and issues of professional satisfaction. According to data from Census 2000, the occupational group with the highest median earnings<sup>514</sup> for year-round, full-time workers in 1999 was physicians and surgeons. While the median for all workers was \$33,000, the only two occupations that exceeded \$100,000 were physicians and surgeons with a median of \$120,000 and dentists with a median of \$100,000 (Weinberg 2004: 7-8). Not all physicians and surgeons fare equally well. Median earnings for physicians and surgeons ranged from a low of \$80,000 to a high of \$150,000 (Weinberg 2004: 25). Looking at median earnings for physicians and surgeons by gender reveals a contrast of \$140,000 for males and \$88,000 for females (Weinberg 2004: 12-13). The ratio of female-to-male median earnings for physicians and surgeons, aged 35-54 years, is 0.628 which is worse than the ratio of 0.714<sup>515</sup> for all year-round, full-time workers in the same age group (Weinberg 2004: 16).

Part of the heterogeneity in earnings may be explained by variance in total compensation by specialty as illustrated in Exhibit 7.1. Estimates of total compensation differ depending on whether the Bureau of Labor Statistics (using Medical Group Management Association<sup>516</sup> data) or the *Medical Economics* Continuing Survey data are consulted but gender disparities remain constant. Total median compensation in the later survey showed \$180,000 for males compared with \$125,000 for females. Interestingly, "among FP's, internists, and pediatricians, the gap is narrowest in family

medicine, where male physicians earned only \$10,000 more than female doctors”

(Guglielmo 2003).

**Exhibit 7.1 Comparison of Total Median Compensation in Dollars for Selected Medical Specialties for the Year 2002, Bureau of Labor Statistics and *Medical Economics* Continuing Survey:**

Specialty	Bureau of Labor Statistics <sup>517</sup>	<i>Medical Economics</i> <sup>518</sup>
Invasive Cardiology		360,000
Anesthesiology	306,964	
Gastroenterology		300,000
Orthopedic surgery		300,000
Non-invasive Cardiology		250,000
Surgery, general	255,438	230,000
Obstetrics/ gynecology	233,061	220,000
Psychiatry	163,144	
Internal medicine	155,530	150,000
Pediatrics/ adolescent medicine	152,690	130,000
Family practice (without obstetrics)	150,267	150,000
General Practitioners		116,000

Variable compensation by specialty is the common rationale to explain earning disparities by gender. “For example, women might choose more frequently than men to practice in lower-paid medical specialties (such as pediatrics) or in lower-paid institutional settings (such as health maintenance organizations)” (Weinberg 2004: 12) (Guglielmo 2003). “Choice” functions in this instance as consoling cooler language. It limits an explanatory model to the free exercise of individual agency thereby diverting attention away from structural analysis of penalties associated with reproductive labor as well as how technological procedures are privileged over primary care. A comparable type of equity question might be to ask why primary care physicians working in university-based settings in 2002 earned approximately \$21,000 less per year than their private sector counterparts and academic specialists earned almost 100,000 less per year than private practice specialists?<sup>519</sup> (Weiss 2003: 56)

Having established that the medical profession is the most highly compensated (if variegated)<sup>520</sup> occupational group in the United States, we might then ask: how is it possible that many physicians feel so oppressed? Consider this expression of outrage written in 1972 in a letter to 5,000 physicians in the San Francisco Bay area by Dr.

Sanford Marcus:

Let's tell it like it is—as a group we study more years, work longer hours, bear more crushing responsibilities, perform greater amounts of free service to our hospitals, teaching institutions, and communities, wade through more burdensome paperwork, are more constantly upgrading our skills, and generally give more of our inner selves to the betterment of society than any other group. We must now proclaim our right to demand appropriate payment for all of this!....It is time we abandoned the canard that unselfish humanitarianism provides our only motivation. We have an unequalled record here, but in a society bent on grinding down the medical profession even our humanitarianism is minimized and ridiculed (Budrys 1997: 9)

This letter resonated with the 500 physicians who responded favorably to it which led to incorporation in the state of California of the Union of American Physicians and Dentists (UAPD) on April 18, 1972. While the topic of physician's unions will be revisited in Chapter Eight, Marcus's litany of grievances is an excellent point of departure for a consideration of this paradoxical phenomenon.

Physicians working in the United States are not unique in their dissatisfactions with their professional lives. Almost thirty years after Marcus's letter, the *British Medical Journal* asked its readers to respond to an online survey of "why are doctors so unhappy?" While being mindful that this self-selective sample of doctors is not representative, it is nonetheless fascinating to note the extent of unhappiness and patterns of attribution for dissatisfaction. There were 806 physicians who classified themselves as "very unhappy" or "unhappy," 308 who were neither happy or unhappy, and 281 self-described as "happy" or "very happy." Most of the respondents (n = 741) were from the United Kingdom but the sample included 42 from the United States, of which 59% were "very unhappy" or "unhappy," 10% were neither happy nor unhappy,

and 30% were “very happy” or “happy” (BMJ Survey: Why Are Doctors So Unhappy? 2001).

**Exhibit 7.2 British Medical Journal Online Survey: Reasons for Unhappiness<sup>521</sup>**

Reason	UK doctors	Non-UK doctors	Total
They are overworked	484	400	884
They are underpaid	327	379	706
They are inadequately supported	327	305	632
They have declining control over their work	238	257	495
They are left picking up the pieces in a society that has lost ways of coping with pain, sickness, and death	273	202	475
Media coverage of doctors is too negative	268	157	425
Politicians are stoking patients’ expectations	281	135	416
The health service is falling apart	259	136	395
Modern medicine promises more than it can deliver	168	157	325
Their status is falling	159	163	322
Too big a gap separates what they have been trained to do and what they have to do	132	144	276
Patients are too demanding	131	142	273
They are exhausted by too much change	135	88	223
They are increasingly accountable	79	96	175
Their close contact with patients has been disrupted	48	67	115

While confirming Marcus’s sense of being overworked, underpaid, over-controlled, and under-appreciated, Exhibit 7.2 situates physicians’ unhappiness within a more fundamental dilemma of discrepancies between expectations commonly held by the public and realities that can be delivered by modern medicine (Smith 2001). Negative media coverage of doctors and political promises that increase expectations are perceived to exacerbate this tension while biomedical interventions often fall short in the presence of increasingly complex social conditions challenging the conditions for health. Paradoxically, as physicians complain about having “to pick up the pieces,” it is the very success of allopathic medicine as a hegemonic, secular, scientific framework that has helped “to erase the memory that pain” once “possessed redemptive and visionary powers” (Morris 1991: 125).<sup>522</sup> Non-biomedical ways of making meaning out of pain,

suffering, and death might provide exactly the alternate means of coping that are now sorely missed.

Moving back to the specific context of doctors in the United States, why are physicians and surgeons describing themselves as “in open revolt” and as a “sullen, demoralized workforce, which is having difficulty in attracting its successors” (Fischer 2003: 8)? One way that this story may be told is as a loss of privilege. Past president of the American Medical Association, Edward Annis, describes the “golden years of medicine” in the tellingly entitled *Code Blue: Health Care in Crisis*<sup>523</sup> as follows:

In those days there was no bureaucratic regimentation, there were few forms to fill out, malpractice premiums were affordable, and the overhead costs of running a practice were reasonable. Our bills were simple, spelled out so anybody could understand them without the use of codes. Patients usually paid their own bills, promptly too, for which an ordinary receipt was given. Hospital charges were set by the day, not by the aspirin. Medical care was affordable to the average person with rates set by the laws of the marketplace, and care was made available to all who requested it regardless of ability to pay. Doctors were well respected; rarely were we denigrated by a hostile press for political reasons. Yes, in the days before government intervention into the practice of medicine, doctor’s fees were low, but the rewards were rich; those were truly “golden years” for medicine (Annis 1993: 21).

This narrative is a classic “story of decline” (Stone 1997b: 138) that is used to define a public problem by arguing that before the laws of the marketplace were interrupted by bureaucratic regulation, costs were reasonable, quality was better as the doctor-patient relationship was undiluted, and equity of access was assured by charitable doctors. This policy story as a “tool of strategy” (Stone 1997b: 162) serves multiple purposes. Using his professional authority as a physician and as a leader affiliated with the American Medical Association, Annis presents to the public a preferred vision of a “free market health care system” at a time when Clinton health care reform initiatives are being widely debated. His basic argument makes the analogy that as the free market “works just fine” for food, automobiles, and houses, that “it will work fine for health care if we withdraw the wedge of third-party players that separates

patients from providers" (Annis 1993: 255). The "normative leap" (Stone 1997b: 156) that Annis asks his readers to make is to consider patients to be fully-informed consumers and credit health care to be a commodity undifferentiated from any other. "What matters is the knowledge that only a free market system provides consumers freedom of choice, and only a free market gives producers the incentives to provide higher quality services at prices consumers can afford" (Annis 1993: 255). What Annis understandably neglects to mention is that the Golden Age mythology was only sustained by the incomplete medicalization of the body in social life. Medicine, as Starr consistently reminds us, is hoist on its own petard as the holy grail of choice intrinsic to the market position allowed itself to charge more than the market could bear.

While colonizing the imaginations of his external audience as a pitch-man for the market, Annis's Reaganesque recollection of the "golden years" is simultaneously targeted at his internal audience of physicians. Although Marcus's solution is forming a union and Annis's solution is the free market, both physicians seem to agree that the problem is "society bent on grinding down the medical profession." Annis's portrayal of the "golden years" as idyllic days without paperwork, huge malpractice premiums or operating costs as compliant consumers presented with payment in hand or hat in hand for charity is linked with "health care in America [that] was second to none" (1993: 20). Lyndon Johnson's Great Society turned from gold to rust as with promises of "the best medical care available through government subsidy...came, inevitably, a wasteful and disruptive bureaucracy that defined basic laws of economics, producing medicine's hyperinflation and fundamentally changing the relationship between doctor and patient" (Annis 1993: 5). Teachings on this changed doctor-patient relationship provide a rationale for physicians to mobilize against third-party wedges even as they resonate with Marcus's outrage at "the way doctors were being treated" which he described as being "pushed off the pedestal" (Budrys 1997: 9).



So what does this have to do with health care reform? It has everything to do with the pursuit of self-regardingness of physicians and their notion of their worth in society. This notion of worth once again gets translated into the contest over how the resources that are brought into health care are going to be distributed. It is significant that while William Osler organized his discourse to address physicians and medical students on the challenges of realizing the qualities of imperturbability and equanimity (1932: 3-11), the *British Medical Journal* online survey was organized around the perhaps more ambitious and controversial notion of happiness.<sup>524</sup> In a capitalist consumer culture, the effective markers of happiness are often money and status that are demonstrated by financial remuneration and acquisition of consumer goods. Physicians, especially those who construct themselves as “businessmen,” may be disconcerted to notice how their fiscal compensation compares unfavorably with the elite discussed in Chapter Two,<sup>525</sup> chief executive officers,<sup>526</sup> media celebrities,<sup>527</sup> and athletic celebrities.<sup>528</sup> The concept of conspicuous consumption introduced originally in 1899 by Thorstein Veblen (1979), may be illustrated in 2004 by breathless accounts in the *New York Times* of a six-egg frittata with lobster, cream, and caviar for \$1,200 with tax and tip (Care for Diamonds With Your Eggs? 2004), a Harry Winston watch for around \$200,000 (Rozhon 2004), and a Mercedes-Benz SLR McLaren silver coupe that was described as “a steal” at \$2.1 million (Healy 2004). Beyond the usual consumer goods, the “latest status symbol” can include “priority medical treatment at Southampton Hospital for 50 wealthy families in return for a ‘membership’ fee<sup>529</sup> (Gaines 2004) or the opportunity to sponsor individual ballet dancers for amounts that range from \$2,500 to \$100,000 per year<sup>530</sup> (Kinetz 2004).

Whether the consumption acquisition is to be eaten, worn, driven, used to engender a state of mind,<sup>531</sup> reproduce high art, or attract attention as visible charity, the cultural capital being amassed can in its turn be viewed as an “instrument of

domination" (Bourdieu 1984: 228). While "competitive consumption" or the "need to keep up" is an old idea in American culture, "mediascapes" of globalization (Appadurai 1996) have redefined reference groups as increasingly the lifestyles of the rich rather than those of similar household means in relatively homogenous neighborhoods (Schor 1999). "Adequate" income becomes an elusive goal as "upscale emulation" makes "luxury, rather than mere comfort" a widespread aspiration (Schor 1999: 2-3). Juliet Schor (1999: 4) argues "upscaling is mainly defensive" in that it has derived from structural changes in society<sup>532</sup> rather than sudden greediness. While Juliet Schor helps to explain patterns of over-consumption exacerbated by globalization, Pierre Bourdieu's analysis of how class status is reproduced in part through everyday consumer behavior highlights how individual consumption has social significance for maintaining structures of power and inequality.

Distribution of resources and consumption patterns in a capitalist consumer society are not neutral or innocent. Chapter Eight will continue this theme by exploring related illustrations of the politics of professional medical labor that have implications for both health and health care reform in the United States.

CHAPTER EIGHT  
“COOLERS”<sup>533</sup> FOR THE MARKET: ORGANIZED MEDICINE’S ROLE IN HEALTH  
CARE REFORM IN THE UNITED STATES

In conjunction with their roles as gatekeepers to health system resources outlined in Chapter Seven, physicians must juggle their often conflicting roles as professionals responsible for the welfare of specific individuals under their care; members of a workforce<sup>534</sup> asked to accommodate to changes in working conditions and remuneration; citizens subsidizing public goods with their tax revenues; beneficiaries of public goods supported by tax revenues; entrepreneurs seeking to maximize their own self-interest; and members of political elites<sup>535</sup> that have accrued cultural and economic capital that may be used in multiple ways. This chapter seeks to amplify the theme introduced in Chapter Seven that physicians’ pursuit of self-regardingness and their notions of their own worth in society get translated into the contest over how health care resources are to be distributed. While Chapter Seven outlines some of the dynamics underlying this pursuit of self-regardingness, Chapter Eight examines how specific professional, entrepreneurial practices in this quest may also be viewed as having implications that include undermining health care systems and subverting possibilities for health.

There is a contested, but ever growing body of scientifically plausible evidence<sup>536</sup> that suggests that the health of populations is profoundly affected by how societies are organized (Black et al. 1992; Evans, Barer, and Marmor 1994). Although the literature may be variously organized around poverty (Leon and Walt 2001), income inequalities (Kawachi, Kennedy, and Wilkinson 1999), social and economic gradients as a key indicator of developmental health of individuals and nations (Keating and Hertzman 1999), social epidemiology (Berkman and Kawachi 2000), social cohesion (Stansfeld 1999), or social determinants of health (Marmot and Wilkinson 1999), a key point of departure within this literature is that morbidity and mortality are inversely related to

one's standing on the social ladder in each society (Wilkinson and Marmot 2003: 10). Put simply, "it is not the richest<sup>537</sup> of the developed countries, but the most egalitarian countries, which have the best health" (Wilkinson 1999a: 492).

After internalizing that social inequalities have an impact on health inequalities, the second important point to frame discussion in this chapter is "social inequality directly shapes inequitable health care systems" (Mackintosh 2001: 187). As social institutions are built out of existing social structures, health care systems both carry a culture's existing inequalities and, at the same time, are "a key site for contestations of existing inequality" (Mackintosh 2001: 175-176). Discourses on health care systems and possibilities for reform are important. "Health care systems shape how we learn who we are in society, what we can expect, how we may behave" (Mackintosh 2001: 188). The following illustrations will suggest that in their pursuit of external validation of their self-worth, organized medicine's practices of operating as coolers for market medicine perpetuate both a dysfunctional medical care system and deepen social inequities that further widen disparities in health.

#### Voting With Their Feet: Exodus From the Profession

Customers, workers, members of trade unions, voluntary associations, and political parties who are dissatisfied with a particular firm or organization typically have two options: they can exit the relationship or they can voice their discontent (Hirschman 1970: 4). Deborah Stone (1997: 33) contrasts a market model of society where individuals attempt to maximize their self-interest through competition with a polis model that takes the unit of analysis to be a community seeking public interest as well as self-interest through cooperation and competition. If, as Hirschman suggests, exit and voice are impersonations of economics and politics respectively (1970: 15), and if economists

have “a bias in favor of exit and against voice” (Hirschman 1970: 17), then perhaps it is unsurprising that “market medicine” so often utilizes exit as a preferred strategy.

Arnold Relman makes a compelling argument that some potential physicians are exiting from medicine before they even begin by choosing alternative careers. The acceptance of more female and minority applicants into medical school is within the context of declining numbers of male white applicants. “Medicine is now viewed by white male college graduates in the United States as a much less attractive career than heretofore” (Relman 1997: 265). Relman attributes this to “the rising cost of medical education and a growing concern about future professional autonomy and economic opportunity” (Relman 1997: 265).<sup>538</sup> As mentioned in Chapter Three, an ominous historical note is that once the sons of the aristocracy deserted medicine for law in early Renaissance Florence, the guild itself lost status once the children of the elite no longer dominated it (Park 1985). This seems congruent with an interview that Helen Dosik did with a physician who did not want his children to go into medicine. When asked who would choose medical school, this physician replied:

Asians, Koreans, Vietnamese, Taiwanese, Indians, some blacks, some Hispanics, a sprinkling of first generation sons and doctors of working class who basically see this as a prestige step up (Dosik 1993: 239).

This loss of prestige and professional authority as more people of color and women<sup>539</sup> enter medicine is exacerbated by negative stereotypes<sup>540</sup> propagated by such authors/media figures as Dr. Michael Crichton.<sup>541</sup> In *Prey*, a suspense novel of nanotechnology running amok causing illness and death, a computer programmer is watching as an intern examines his daughter:

He was very calm, standing there, frowning and thinking. I wondered if perhaps he was just dumb. The best people weren't going into medicine anymore, not with the HMOs running everything. This kid might be one of the new breed of dumb doctor (Crichton 2002: 40-41).

That “the new breed of dumb doctor” that Crichton so pejoratively dismisses is increasingly unlikely to look like him is not accidental just as his remarks are not innocent. As the medical profession is portrayed as “degraded” by feminization and changing ethnic and class participation,<sup>542</sup> negative stereotypes harm patients as well as physicians. Survey research derived from samples of people attending a low-income clinic, low-income individuals with HIV disease, and homeless people “as a whole indicated that individuals who held more negative stereotypes about health care providers were less likely to seek care when sick, were less likely to be satisfied with the care that they did obtain, and were less likely to adhere to physician recommendations for treatment” (Bogart et al. 2004: 1056).<sup>543</sup>

Moving from exiting the profession by never entering it, we may now turn to an extensive literature linking job satisfaction, stress, mental and physical health, and remuneration with physicians’ intentions to leave a practice (Williams et al. 2001; Pathman et al. 2002). The exit of a physician from one practice setting to another or out of the profession of medicine entirely is expensive both on the personal level for the physician and as an institutional cost. The estimated recruitment and replacement costs per physician are \$236,383 for general/family practice, \$245,128 for internal medicine, and \$264,645 for pediatrics (Buchbinder et al. 1999: 1431).<sup>544</sup>

### Fleeing the Polis: Fraying Safety Nets, Eschewing Insurance Revenues and Growing Niche Markets

Having paid a “high fee” for entry into medicine by virtue of its “severe initiation” or socialization process as described earlier, leaving the profession altogether might be considered by many physicians to have a “high-exit price” in Hirschman’s terms.<sup>545</sup> Instead of exiting medicine completely, a common strategy is to exit from ways of practicing medicine that are other than market-orientated. While it can be argued that

from Plato<sup>546</sup> through the examples given in Chapter Three that healing has long been contested as an entrepreneurial activity, the following examples will illustrate the extent to which some physicians practice and defend a monotheist vision of medical care as a commodity.

The lower slung safety net discussed in Chapter Four is “in danger of fraying”<sup>547</sup> as the proportion of physicians providing charity care drops. Between 1996-1997 and 1998-1999, the percentage of patient care physicians providing charity care declined from 76 percent to 72 percent in the Center for the Study of Health System Change Community Tracking Study Physician Survey (Reed, Cunningham, and Stoddard 2001: 1). Previously discussed trends, such as increasing numbers of physicians working as employees rather than owners of their practices and increased pressure on doctors’ time, are factors associated with decreased proportions of physicians giving charity care<sup>548</sup> (Reed, Cunningham, and Stoddard 2001: 2). Marie Reed and Paul Ginsburg suggest “the real-dollar decline in physicians’ income may help to explain the intensity of organized medicine’s objections to recent cuts in payment rates in Medicare as well as decreased physician participation in charity care” (2003: 2).

Patients seeking charity medical care are not the only ones who have difficulty accessing medical care. Physicians often “boycott Medicaid patients” by refusing to accept or severely limiting the number of Medicaid patients they will see (Weiss 1997: 181).<sup>549</sup> Boycotting publicly insured patients helps to explain why the Center for the Study of Health System Change reported in June 2004 that “significant safety net gaps remain” (Felland, Felt-Lisk, and McHugh 2004: 1). In their site visits to “12 nationally representative communities,”<sup>550</sup> 10 of the 12 communities reported “low-income people have great difficulty obtaining specialty care, and observers in six communities indicated that access has declined over the last two year” (Felland, Felt-Lisk, and McHugh 2004: 1). Five specialties were identified across communities as being

“particularly difficult to gain referrals: gastroenterology, orthopedics, cardiology, endocrinology and dermatology” (Felland, Felt-Lisk, and McHugh 2004: 1). “Low Medicaid and SCHIP payment rates—especially relative to commercial payments—were cited as major obstacles to provider participation” (Felland, Felt-Lisk, and McHugh 2004: 2) even as the alert reader will have noticed that the first three specialties listed as hardest to access are among the highest in total median compensation in Table 7.2. Physicians who are more likely to provide care to greater number of Medicaid patients have been characterized as having “marginal social statuses” (female, minority, foreign-born) that further “accumulate marginality” by practicing lower prestige, lower paying primary care in high poverty, high minority population areas (Hynes 1995: 117-120).

Rationales of low reimbursement rates<sup>551</sup> and fears of malpractice claims<sup>552</sup> that have traditionally been cited as disincentives to care for Medicaid patients have also been used as justification by physicians for “shunning” Medicare patients. In response to Medicare payment cuts to physicians by 5.4 percent in 2002, the American Academy of Family Physicians reported “17 percent of family doctors are not taking new Medicare patients” (Pear 2002). Dr. Paul Buehrens, medical director of a clinic with 22 doctors in Kirkland, Washington said, “we have closed our practice to new Medicare and new Medicaid patients. At current payment rates, he said ‘Medicare is almost charity care’” (Pear 2002). President-elect of the Texas Academy of Family Physicians, Dr. Robert Hogue, went even further in his office practice policy by initiating preemptive action: “I have a hard and fast rule. I don’t take any new Medicare patients. In fact, I don’t take any new patients over the age of 60 because they will be on Medicare in the next five years” (Pear 2002). Interestingly, even as the physicians interviewed were shedding Medicare patients, Los Angeles internist, Dr. Samuel Fink, expressed “the opinion of many doctors: ‘I fear for when I become a senior. It will be harder for seniors to find



good care. Across the country, Medicare patients are become less and less desirable to physicians’” (Pear 2002).

Moving ahead to 2004, many of the dynamics remain the same. A 17% increase in Medicare premiums<sup>553</sup> “resulting largely from increased payments to doctors and rising medical expenses generally” was described as a “body blow” to the elderly (Harris 2004). Effective lobbying by physicians against Medicare price controls greatly contributed to this premium increase. Oncologists are currently threatening to reduce services to patients or use older, more toxic chemotherapy unless Congress increases payment to them (Harris 2004).

#### Generating Demand for Non-Insured Procedures: How Cosmetic Surgery Drives Out Reconstructive Surgery

Choosing a specialty (such as dermatology, ophthalmology, or plastic surgery) and then organizing a medical practice to maximize opportunities to generate revenue from performing procedures that are not medically necessary, but are increasingly popular as enhancement technologies, is an effective way to exit from thrall to the insurance industry nexus or public insurance programs.<sup>554</sup> A series of articles written by Lloyd Krieger, MD, MBA as the main author, supported by research grants from the American Society for Aesthetic Plastic Surgeons, provides a helpful window into the dynamics and rhetoric of market medicine using plastic surgery as the paradigmatic illustration.

According to *Medical Economics* data, plastic surgery incomes were flat from 1992 to 1996, took a drop in 1997, and then increased again in 1998 and 1999. The American Medical Group Association data show that plastic surgeon incomes were \$286,507 in 1999 and have remained essentially unchanged since then (Krieger and Lee 2004: 193).

Plastic surgeons complain about “essentially steady” income that remained unchanged in real dollars even as they have increased their surgical load by an average

of 41 percent over the past 10 years (Krieger and Lee 2004: 192). "In short, plastic surgeons have taken aggressive steps to change their practice patterns to cope with economic realities on the ground, and the result has been the mere maintenance of the financial status quo" (Krieger and Lee 2004: 196). Krieger and Lee's disappointment with the "mere maintenance of the financial status quo," although relatively better than many other specialties and significantly better than other professional groups, may perhaps be attributed to a view of themselves as rational economic actors. "Plastic surgeons are truly economic creatures who must adapt to their complex financial environment ruled by both the classic laws of supply and demand and the often perverse effects of third-party reimbursement" (Krieger and Lee 2004: 196).

Research into the supply side of plastic surgeon capacity suggests that a 30 percent national increase in the supply of plastic surgeons would lower fees by approximately 32 percent (Krieger and Shaw 1999b: 559). On the demand side, the total number of cosmetic procedures performed just by members of the American Society of Plastic Surgeons (ASPS) increased by 424 percent from 389,024 in 1992 to 2,878,212 in 2003 (ASPS 2004a). There were 887,553 Botox injections given by ASPS members in 2003 while the five top cosmetic surgical procedures in order were breast augmentation, liposuction, eyelid surgery, tummy tuck, and facelift (ASPS 2004b). The overall size of the aesthetic plastic surgery market is projected to increase by 19 percent by the year 2010 (Krieger and Shaw 1999a: 2314). An increased supply of surgeons performing breast augmentation and providing treatment of male pattern baldness was offset by increased consumer demand for both of these procedures so that fees remained steady and rose respectively for those procedures between 1992 and 1997 (Krieger and Shaw 1999a). While increasing demand saved an increased supply of plastic surgeons from fee reductions in these examples, supply and demand is not something to be left to chance:

The health economist Victor R. Fuchs famously argued that when confronted with shifting supply curves, surgeons respond by acting to shift the demand curve. In doing so, they preserve their overall income by inducing demand for their services. The same might be argued for plastic surgeons. Given that there is no mechanism to control the total numbers of physicians performing aesthetic surgery, the question becomes how to preserve the financial viability of the enterprise (Krieger and Shaw 1999b: 562).

Controlling the total number of physicians performing aesthetic surgery is a challenge given that there are about 6,600 plastic surgeons certified by the American Board of Plastic Surgery and “most estimates suggest that there are three to four times that number of practitioners performing cosmetic surgery without board certification” (Kuczynski 2004). While some plastic surgeons urge a reduction in the number of plastic surgeons trained per year and an increase in the length of the plastic surgery residency (Pearl 1999: 565), this does not address “doctors of every stripe—dermatologists, gastroenterologists, gynecologists—[who] are cashing in and performing cosmetic surgery” (Kuczynski 2004). Even less does a reduction in plastic surgeons reduce a potential increase in provider supply from California Senate Bill 1336, which if enacted would allow oral and maxillofacial surgeons to perform cosmetic surgery on the face (Kuczynski 2004). “Apoplectic”<sup>555</sup> responses by plastic surgeons as these professional groups jostle for position<sup>556</sup> are meant to bolster the incumbents’ professional power<sup>557</sup> by delegitimizing any serious consideration of this threat to their income stream. The plastic surgeons in this instance predictably “invoke state assistance in competition, usually under the rhetoric of putting down dangerous quacks” (Abbott 1988: 137). “Plastic surgeons insist that only they can provide the highest quality of care”<sup>558</sup> while oral and maxillofacial surgeons insist just as vehemently that they are “treated unfairly, considering their level of training and skills”<sup>559</sup> (Kuczynski 2004).

While the merits of various forms of professional birth control are debated, “emphasis on increasing demand is a reasonable approach to maintaining the economic

viability of aesthetic surgery” (Krieger and Shaw 1999a: 2316). Given that 93 percent of surveyed plastic surgeons categorized the majority of their patients as “very or moderately price-sensitive” and 98 percent of the surgeons described their “business climate as very or moderately competitive,” Krieger discusses three protocols for success as discounting, differentiation, and focus (Krieger 2002b: 614). In an article entitled “Cosmetic Surgery in Times of Recession: Macroeconomics for Plastic Surgeons,” Krieger cautions not against any of the themes discussed in Chapter Four but against too much discounting as it will negatively effect differentiation and focus. Consider the following rationale and example:

The temptation is to lower prices to increase volume. However, it is important not to alter the positioning of a product or service within its market—that is, not to cheapen the brand...Those businesses targeting very-high end customers almost never offer discounts, no matter how severe the economic downturn. They are concerned that their luxury status will be diluted or lost...For example, Gucci recently changed its promotional focus at fashion shows, advertising, and store displays from high-couture items to more pedestrian—though still expensive—products. It replaced the promotion of \$3000 blouses with that for \$500 handbags...Plastic surgeons who have spent years developing a “Park Avenue” practice should be similarly wary of indiscriminate price decreases and take innovative steps to avoid them. They might offer more patients Botox treatments, for example, as a bridge measure until they are ready to proceed with a more expensive invasive procedure (Krieger 2002a: 1350-1351).

Besides being a dazzling display of the trajectory of Thornstein Veblen’s (1979) notion of “conspicuous consumption” and of using academic capital to generate financial capital through cultural capital (Bourdieu 1984), this passage illustrates the more mundane point that generating demand is a deliberate activity. Deborah Sullivan (2001) has traced an often sordid history of savage infighting among physicians as aspirations to generate demand through advertising competed with understandings of scientific and professional authority that could be compromised by commercialism. Changing mores over time may be illustrated by the assumptions implicit in Krieger’s Gucci tutorial with early outrage against paid advertisement in this 1977 editorial in the

same professional journal, *Plastic and Reconstructive Surgery*,<sup>560</sup> that published Krieger's articles:

What can certification by ABPS [American Board of Plastic Surgery]...mean to the public if physicians (even a few) are willing to prostitute themselves and their profession by participating in such ethical cesspools? (Sullivan 2001: 138)

Feminists and cultural studies scholars have pointed out that a dark side of generating demand<sup>561</sup> is that it sustains "an increasingly normative cultural practice" that "is a significant contributory *cause* of women's suffering by continually upping the ante on what counts as an acceptable face and body" (Bordo 1997: 43). What is acceptable may extend to surgeries to erase ethnic and racial features<sup>562</sup> to a more "white" norm (Bordo 1997: 49) or to modify facial characteristics of children with Down's syndrome "to reduce stigma" (Sullivan 2001: 67). Creating demand through "technological imperialism"<sup>563</sup> blurs distinctions between "scalpel slaves," who "seek a sense of self-worth and happiness through multiple operations" (Sullivan 2001: 179) and loyal customers who routinely turn to surgery as habitual practices of "correcting" for age (Bordo 1997: 45).<sup>564</sup> By 2003-2004 the demand curve is also shifted by a cultural fascination with "reality" television shows such as *Extreme Plastic Surgery*, *Nip/Tuck*, *Extreme Makeover*, and *The Swan* that show gory surgical footage along with fairy-tale transformations of ducklings into now-lovable swans of desire.<sup>565</sup> This cultural context makes Professor Sandra Gilman's prediction plausible: "By the year 2020, no one will ask you whether you've had aesthetic surgery, they will ask you why you *didn't* have aesthetic surgery" (Campbell 2003).

This explosion in demand should be reassuring to the more than 47 percent of survey respondents<sup>566</sup> from the American Society for Aesthetic Plastic Surgery who already earned 75 to 100 percent of their practice revenue from aesthetic surgery in the late 1990's (Krieger and Shaw 1999c: 2306). This leads to a dilemma that is familiar from

Chapter Five's discussion of pharmaceutical research of practice patterns following revenue generating opportunities rather than other decision-making criteria such as medical necessity or improved function. The average plastic surgeon's total surgical volume in 1992 consisted of 27 percent cosmetic and 73 percent reconstructive surgeries. By 2002, 58 percent of all surgical procedures performed were cosmetic and only 42 percent were reconstructive<sup>567</sup> (Krieger and Lee 2004: 194). It is instructive to note Krieger and Lee (2004: 196) attribute this increase in the percentage of cash-paying cosmetic surgery procedures "almost certainly as a result" of declining Medicare reimbursement for reconstructive surgery. The question related to both exit and voice that these authors then pose is:

If plastic surgeons become less willing to perform reconstructive procedures because of declining surgeon fees, who will shoulder the responsibility of caring for those patients? There is no question that there will always be a need for reconstructive surgery, but the opportunity costs of performing reconstructive surgery over cosmetic surgery are so great that fewer and fewer plastic surgeons may be able to resist the economic pressure for very long (Krieger and Lee 2004: 198).

These free market actors suggest without irony<sup>568</sup> that increased Medicare reimbursement for reconstructive surgery and a regulatory framework to decrease competition "such that only qualified individuals of appropriate training and background are allowed to perform cosmetic surgery" would assist with this economic pressure (Krieger and Lee 2004: 197). If the practice of plastic surgery is limited to the logic of the marketplace, breast augmentation, liposuction, and Botox will drive out cleft lip/palate repair and surgery to release contractures that impair mobility from severe burns. Plastic surgeons are coolers in this instance as they promote practices of economic determinism to privilege their own economic self-interest<sup>569</sup> to the loss of every other consideration.

### Generating Demand for Luxury Medical Care: How Boutique Medicine Becomes Routinized as Retainer Practices

The next illustration of physicians as coolers for the market has many of the characteristics of plastic surgery niche marketing but involves physicians from a variety of primary care and specialty fields. Serving the needs and desires of the carriage trade is not a new phenomenon in medicine.<sup>570</sup> “Boutique,” “concierge,” “premium,” “luxury,” “platinum,” or most recently, “retainer” practices are particularly rich examples of physicians’ rhetorical deftness as the values of efficiency/cost, quality, and equity inherent to health care reform debate jostle for position.

The first of the boutique or concierge physician practices started in Seattle in 1996 under the brand name MD2 (pronounced MD-squared)<sup>571</sup> (Wiebe 2002: 1). Characterized as a revolt against the pressures of managed care, concierge doctors care for a small panel of elite patients for fees that range nationally from \$1,500 to \$20,000 per year (Linn 2001).<sup>572</sup> Perks differ from practice to practice but most share attributes of only having to wait a few minutes to arrange for an appointment, being seen by the doctor on the same day as the appointment is made, home visits, extended visits including the right to call the physician twenty-four hours per day on his or her cell phone, extensive preventive health counseling, as well as improved emergency and specialty care.<sup>573</sup>

Customers in this niche market are described as “the same people who send their children to private schools” and as “incredibly mobile people, with multiple homes” (Wiebe 2002). Although representative data are not readily available, nearly three-quarters of the Dare Center patients in Seattle are between 51 and 80 years of age and 58% are male (Slomski 2000). Clients<sup>574</sup> for teaching hospital-based executive health programs have been described as mostly “asymptomatic, fairly healthy, and come from upper management (i.e., disproportionately white men)” (Donohoe 2004a: 91).

Marketing is often directed at the conspicuously busy as vice president of Virginia Mason Medical Center explained, "This is a program for patients who value their time" (Slomski 2000).<sup>575</sup> Conspicuous consumption is once again a factor in this niche marketing as the title of one industry publication suggests: "If You Have to Ask, You Can't Afford it" (Romano 2002).

A strategic representation of medical care as a consumption choice of an individual consumer is strengthened by frequent use of private education as a preferred analogy.<sup>576</sup> Darin Engelhardt, chief financial officer of MDVIP, said "the concierge alternative is the same as a parent's decision to send a child to private school...It's a niche...But people who want to enhance their lives shouldn't be denied the opportunity to do so with their personal funds" (Romano 2002). In this framing: "like private education, luxury primary care is simply a response to a market need" (Brennan 2002: 1166). This extra enhancement, like many wants or "market needs," has the potential to transform itself into a strongly prioritized actual need. Bob Sarge, a 70 year old patient who pays \$3,000 per year to see his Seattle internist, John Kirkpatrick, initially thought the service was a luxury "but now I think of it as a necessity"<sup>577</sup> (Slomski 2000).

Boutique medicine has been framed as a quest to return to the "Golden Age of Medicine" (Donohoe 2004b), as "an exit strategy" for those seeking "cash customers" in a changing health care market (Kennedy 1996), and as "a symptom the whole health care non-system is unraveling"<sup>578</sup> (Connolly 2002). On the nostalgia side, two Louisville, Kentucky physicians who plan to reduce their practice numbers by 90 percent to provide "exhaustive physicals, 24-hour access, same-day appointments, and in general, tender loving care" explained: "Both of our fathers are physicians, and both have said, 'Now you'll know the joys of practicing medicine the way I used to practice it'" (Associated Press 2002). Dr. Richard Goldman defended his new boutique practice as a return to "the reasons he went into medicine in the first place" (Stewart 2002). "This is



the only way I can get back to practicing the kind of care I want to provide," he said. "The premise of this practice is giving people choices instead of the restrictive choices managed care inflicts on them" (Stewart 2002).

Critics of managed care suggest that boutique practices are both a symptom of and "an antidote" to doctor's frustrations (Baker 2002). Richard Roberts, MD, JD, board chairperson of the American Academy of Family Physicians argues, "This really is symptomatic of a sick system<sup>579</sup> that has very uneven coverage and physicians who are struggling. What you're seeing for many of these doctors is such an overwhelming frustration with the current structure and financing of the system that, in a sense, they're bailing out" (Baker 2002). This movement toward concierge practices serves both as an exit strategy as physicians bail out and as a voice strategy as this trend toward luxury medicine is heralded as a "wake-up call"<sup>580</sup> (Associated Press 2002). Crisis and need for reform are constitutive parts of this reveille sounded by luxury medicine proponents:

"I think all of medicine is looking at something else," said Judith C. Worland, chief executive officer for AccessMD. Images of doctors picketing and going on strike drive home the point, she said. "I think we are in a crisis. There will be a lot of different ways medicine will change," she said (Smith 2003).

Just as in organized medicine's rhetoric of opposition to all but fee for service practice patterns in Chapter Three, physicians' discourse defending concierge medicine is often framed as a reflection of patients' choice and in their best interests. Herbert Rubin of Beverly Hills explained that he is making more because he is charging more but the patients are benefiting more as "paying customers:"

Of course my patients get more time and attention from me; they're now paying customers. They get what they pay for when they choose managed care, and they get what they pay for when they get me. My attitude is that I'm the best doctor in the country, and I give them great medical care (Slomski 2000).

Spending more time with fewer patients for greater financial remuneration is more satisfying for both physicians and patients according to Dr. Mitchell Karton of Seattle Medical Associates:

There is a collegial feeling that doctors and patients are working together, whereas formerly we all felt devalued, invisible, and a generic part of a bigger system. We feel we've created a first-rate practice with all the things a patient should have (Slomski 2000).

Sometimes "all the things that a patient should have" means physicians advocating for preferential treatment as Karton's partner, Dr. Garrison Bliss, explains:

We'll call a specialist who has no room on his schedule for six weeks, and by being pushy, nagging, and difficult, we may get him to see our patient during his lunch hour. Doctors tolerate this from us because they know we are trying to give good care to our patients (Slomski 2000).

Quality of care is often highlighted as a premier virtue of platinum practices, even when this quality is obtained at a cost borne by others unacknowledged in the dynamics of boutique medicine.

While some critics describe "white-glove medical service" as "greedy, unconscionable and possibly illegal" (Hundley 2001), others suggest boutique practices, such as the Dare Center, have "used the extra dollars to support its free care of the poor" (Wiebe 2002). Some physicians suggest luxury practices are a way to redistribute resources in ways that might benefit the poor. "Busch describes himself as a modern-day Robin Hood—the money he makes from wealthy clients frees up time to volunteer at an urban clinic" (Connolly 2002).<sup>581</sup>

When internists Steven Flier and Jordan Busch left Beth Israel Deaconess Medical Center to start their own boutique practice they "set off a 'moral earthquake' in Massachusetts medical circles" (Connolly 2002). Harvard Medical School professor John Goodson argued in the *Boston Globe* "a change toward elitism in the delivery of health care is pernicious. It undermines the most fundamental commitments of our profession" (Connolly 2002). As a primary care physician, Goodson joins the critics of boutique

medicine who see it as “the first step toward an even more ruthlessly capitalist health-care system” (Friedman 2002). Goodson argues:

...concierge practices are a slow-developing apocalypse for the medical system. “Think about this in a macro way,” Goodson says. “Say you lose 10 or 15 percent of your doctors. In the overall system, you end up reducing by a significant percentage the patient-hours of care, and everyone else who’s left behind is suddenly working harder. There is already a shortage of primary-care docs. What’s to prevent any doctor from starting to charge fees? The whole thing could mean the Balkanization of American medicine” (Friedman 2002).

Just as insurance companies<sup>582</sup> may try to “cherry pick” the healthy over the sick, this form of Balkanization is argued to raise costs by altering the risk pool:

“It makes me sad,” says Richard Roberts, a family practitioner in Belleville, Wis., who is president of the American Academy of Family Physicians. “For one thing, it purports to offer what all good primary-care doctors should offer, ready access and personalized care. This is a classic underwriting technique called skimming. What will happen is that poor people, who can’t afford this, won’t get it, and their costs will be foisted on everyone else (in higher insurance premiums and taxes)” (Romano and Benko 2001).

Paul Ginsburg, from the Center for Studying Health System Change, described boutique practices as “an end run around Medicare” as he articulated concern about decreasing access with increasingly tiered medicine<sup>583</sup> (Romano and Benko 2001). Increasing costs generated by raising expectations<sup>584</sup> to a more luxurious community standard of care and decreasing access by overworking the remaining physicians available does not look promising for improving the overall quality of care in the health care system. Instead, Uwe Reinhardt argues, “wittingly or not, they merely redistribute superior quality towards patients thought to deserve it, because they can and will pay for it” (Connolly 2002). In contrast to the Robin Hood rationalization, Troyen Brennan (2002: 1167) argues that luxury primary care decreases access by undermining cross-subsidization of those with poor insurance by those with good insurance coverage on which the American health care system has been dependent for the past 50 years.<sup>585</sup>

Ethicist Virginia Sharpe of the Hasting Center articulates a critique of boutique medicine based on a premise of medical care as a public good:

“Medical education is heavily subsidized by the citizens of the United States,” she says. “Therefore, everyone should have access to that knowledge because it’s not proprietary...giving greater advantage to people who can pay more simply deepens the flaws in the system—it doesn’t fix them. If we had high standards of care available to everyone, these premium services would be less morally offensive” (Slomski 2000).

This invites the discussion back to parallels that may be drawn between luxury medicine and private education in that an abandonment of each by the more affluent sectors of society decreases incentives for increased commitment to health and education as public goods. Although the argument is sometimes made that separate services for the rich leave more resources available for the non-affluent in publicly funded systems, the actual dynamics are that fewer and poorer resources are allocated once the stakes are not universal. One should then be wary of ghettoizing medicine even further:

“If these are things we believe every patient should have and every doctor should have, we should be trying to build a health-care system where everybody gets it,” said George Annas, chair of the health law department at Boston University’s School of Public Health. “The more we ghettoize medicine in this way, the more people with power and influence in our society don’t care about universal health care” (Stewart 2002).

Ellen Shaffer’s metaphor<sup>586</sup> to describe boutique medicine is “gated community for health care” (Colliver 2003). This image may be set along side of Dr. Levine’s analogy:

“Look, there are 40 million people uninsured in this country,” Levine says. “And I think that’s a problem that should be fixed. But this practice is not a solution for the whole system. We’re not looking to do that. If you want to solve the homeless problem, you build low-income housing. You don’t stop people from buying mansions. We’re just looking to create a model<sup>587</sup> that can be looked at, tweaked, changed and then used” (Friedman 2002).

Gated community and housing for homeless people/ mansions juxtapositions are perfect tropes in a context of increasing social stratification and wealth/income inequalities driven by the dynamics of globalization. Levine’s ability to frame these kinds of housing

alternatives as two discrete phenomena rather than interrelated dynamics distinguished by differential access to finite material resources that are distributed in concordance with how this particular culture is constructed provides excellent rationalization for building McMansions and platinum practices. “Dr. Levine’s Dilemma”<sup>588</sup> might be considered to be a morality play unfolding in the pages of the *New York Times*. Devin Friedman notes that over his days spent talking with Levine, Levine was “steadfastly reluctant” to admit that any criticism of physicians engaged in boutique medicine might be legitimate:

At the end of our conversation, though, he finally acknowledges that his critics might have patients’ best interests at heart. ‘O.K., the worry would be: Am I opening some kind of Pandora’s box? Will this push us even more toward multitiered medicine? Those things make you toss and turn.’ As Levine talks, it’s easy to believe this would be a genuine nightmare for him. ‘We’re not trying to create an unfair system,’ he emphasizes one more time. ‘But if it comes about, I hope people won’t say, ‘We were following their lead.’ We want it to be a model for good care, not disparate care’ (Friedman 2002).

Being a cooler for multi-tiered, concierge medicine that promises “good care, not disparate care” is born out of a longing for Levine that “my life should be the focus of my life” (Friedman 2002) but it also necessitates a capacity for willful disingenuousness or willful innocence of Reaganesque proportions.

Two of the ways that willful innocence may be facilitated is through “mainstreaming” of the concept and by diction that softens the harsher edges of reality. These come together when physicians “bring boutique practices to the masses” as the number of practices that charge \$1,500 and \$2,000 per year now outnumber the \$20,000 annual fees that were characteristic of the first practices (Norbut 2003). Dr. Daniel Frank, who “wanted to treat all of his patients as if they were his own family members,” charges only \$99 a month or about \$3.30 per day (Norbut 2003):

The way he figures it, the cost of membership to his practice is comparable to what his patients would spend each day on a grande Iced Caffe Mocha at Starbucks. “My goal is to make it widely available to the middle class,” Dr. Frank said. “For the patients who pay that extra \$99, it makes their experience unbelievably better” (Norbut 2003).

Large medical groups, nonprofit organizations, (Norbut 2003) and academic medical centers<sup>589</sup> (Donohoe 2004a) are routinely offering these preferential services as part of their practices. “Boutique” or “concierge” practices have taken on a softer and “less exclusive-sounding name: retainer practices” as their popularity has been growing (Norbut 2003). The chief financial officer and general counsel for MDVIP Inc., Darin Engelhardt, says, “‘retainer’ doesn’t necessarily have the same elitist connotations...we refer to it as personalized health care, ourselves” (Norbut 2003). Retainer practices, of course, do not “extra bill” but have lawyers to organize systems for “balanced billing” (Kowalczyk 2001). The use of such terms as “fair” and “balanced” to describe billing becomes important when trying to persuade of the righteousness of physicians’ claims as striking physicians in Ontario discovered in 1987 when they faced an unsympathetic public informed by media accounts of “extra billing” (Carney 1996).

While critics of retainer practices are concerned that a widespread adoption of this model might threaten access to medical services for the non-cream<sup>590</sup> not skimmed into these practices, Dr. Frank prefers the market logic of the cosmetic surgeons. “‘The value of this trend is the more competition and the more market forces you can bring in, the better,’ Dr. Frank said” (Norbut 2003). By generating enough demand, even a boutique practice targeting the middle class, such as Dr. Frank’s, can “eclipse that of a traditional practice:” “If you have 500 patients and charge \$100 a month, that’s \$50,000 you start with each month—and \$600,000 that you have at the end of the year—without even seeing a patient” (Norbut 2003).<sup>591</sup> This actually seems to be more lucrative for the individual physician than the more exclusive retainer practice exemplified by MD2. Their business plan, according to Duane Dobrowits, chief executive officer of MD2, “was to go national, with plans to open as many as 100 to 200 franchises across the country within five years. ‘We believe that every major city has at least 100 families willing to

pay for this kind of care,” (Romano and Benko 2001). Franchisee fees are \$75,000 and come with specific requirements:

Each franchise must consist of a pair of internists who have affiliations with prestigious hospitals in their markets. The company is interested in doctors who are already treating the well-heeled. And franchisees must be prepared to recreate the plush office environment, complete with antique art work and marble-lined bathrooms. Physicians pay a 5% royalty fee on top of the \$75,000, and should expect annual overhead to run around \$1 million for staff, medical equipment, and other expenses. But each doctor can walk away with \$300,000 to \$500,000 per year from the practice, Dobrowits says (Romano and Benko 2001).

The legality of boutique practices is under extensive scrutiny. Medicare was reviewing MDVIP in Florida for possibly charging patients extra for services already paid for by Medicare in response to dropped patients complaints of being “ABC’d by MDVIP: Abandoned, Betrayed, and Cast aside” (Kowalczyk 2001). Citing the example of a physician<sup>592</sup> who violated his Medicare assignment agreement by asking his patients—including Medicare beneficiaries—to pay an annual fee of \$600 for a “Personal Health Care Medical Care Contract,” for services that included those that were already reimbursable by Medicare, the Department of Health and Human Services warned:

We are hearing reports about physicians asking patients to pay additional fees, and we believe this is an ideal time to remind physicians and Medicare patients about this potential liability. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid by Medicare (Office of the Inspector General 2004).

As Medicare coverage expands to reimburse such items as annual physicals, “it’s getting harder for concierge practices to find uncovered services to justify the extra fees” (Hawryluk 2004). The previously mentioned Dr. Bliss, of Seattle Medical Associates, avoids potential conflicts “by not billing the program or any other insurer:”

“Our model, where we fully separate ourselves from all insurance money, is a rare one,” he said. “I think most doctors would like to have the insurance companies paying for services, and they would like to supplement that with some income from the patient. Those are going to be the least expensive systems for patients” (Hawryluk 2004)

This would not, of course, be the least expensive model for the system as a whole.

The Council on Medical Services of the American Medical Association concluded in its report to the House of Delegates in 2002 that “retainer practices were consistent with long-standing AMA support of pluralism in the delivery and financing of healthcare” (Council on Ethical and Judicial Affairs 2003: 1). The Council on Ethical and Judicial Affairs was asked to sign off on retainer practices for a second time as the first opinion “concentrated too much on the negative aspects of these practices” (Peck 2003). After toning down these concerns and emphasizing that “contract-type practices might be a way ‘for patients to establish trust in a physician’” (Peck 2003), guidelines on retainer practices were approved by the AMA House of Delegates at its 2003 Annual Meeting (Keeping It Ethical: Retainer Practices Have Rules and Restrictions 2004).<sup>593</sup>

The Council on Ethical and Judicial Affairs has a clear recognition of critics’ concerns that “if these practices become widespread, the number of physicians not engaging in such contracts would be insufficient to provide medical care to all patients who are unable or unwilling to pay the additional fees” (Council on Ethical and Judicial Affairs 2003: 3). This 2003 policy document affirms Principle IX of the AMA’s *Principles of Medical Ethics* that “physicians shall support access to medical care for all people” (Council on Ethical and Judicial Affairs 2003: 3) while citing Opinion E-10.05 that:

Physicians, as professionals and members of society, should work to assure access to adequate health care. Accordingly, physicians have an obligation to share in providing charity care but not to the degree that would seriously compromise the care provided to existing patients (Council on Ethical and Judicial Affairs 2003: 4).

This leaves the authors of this ethical framework in the paradoxical situation of advocating some kind of medical care (medical care or “adequate” medical care) as an end without a commensurable commitment to the means that might be required to achieve that goal. This preference for existing patients over potential patients (who might be in greater clinical need) and advocacy for optional, qualified charity<sup>594</sup> rather



than a human rights or social justice approach to medicine is as inconsistent as their statement on quality of care in the boutique medicine context:

Concern for quality of care the patient receives should be the physician's first consideration. However, it is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services. Physicians must always ensure that medical care is provided on the basis of scientific evidence, sound medical judgment, relevant professional guidelines, and concern for economic prudence (Council on Ethical and Judicial Affairs 2003: 5).

It seems clear from the physicians' point of view that cash in hand will provide an "unbelievably better" experience as patients "get what they pay for." The contradictory<sup>595</sup> message that the American Medical Association sent with its "lukewarm blessing" is that "medical care should have nothing to do with the patient's ability to pay" AND "there is nothing inherently unethical about entering into a contractual relationship with a patient" as it is an extension of the "AMA's support of pluralism in medicine" (Peck 2003).

Critics of luxury medicine point to ethical,<sup>596</sup> professional, and pragmatic areas of concern that are not fully addressed by the American Medical Association's stance. Brennan (2002: 1167) argues that the "simply filling a small niche" that does not threaten health care access in general justification is suspect due to its situational nature which "flies in the face of standard professional principles."<sup>597</sup> "The use of clinically unjustifiable tests erodes the scientific underpinnings of medical practice;" scientific and professional ethics may be eroded as "a 'buffet' approach to diagnosis makes a mockery of evidence-based medical care" (Donohoe 2004a: 92). Some physicians find retainer practices distasteful for reasons of class association linked with their sensibilities as professionals. An argument against boutique medicine in the *Journal of Vascular Surgery*, for example, concludes that not only is the practice unethical but it is equivalent to tipping<sup>598</sup> thereby suggesting "a degree of abasement unworthy of our profession" (Jones, McCullough, and Richman 2004: 1355). A pragmatic critique simply raises

doubts by describing the dynamics of luxury medicine as “a variation of Ronald Reagan’s failed trickle down economic theory of the 1980s (Donohoe 2004a: 93).

Although direct reimbursement for cosmetic surgery and boutique medicine practices seem to be a return to direct fee for service<sup>599</sup> contractual medicine, it is a bit unclear whether some concierge practices might also have some characteristics of insurance plans or health maintenance organizations. On one hand, “some doctors say ‘boutique’ is just a new term for an old concept: refusing to accept insurance” (Evans 2002). On the other hand, Dr. Vic Woods is under investigation in the context of his boutique-style practice by the West Virginia Insurance Commission “for possibly selling insurance in violation of state law” (Norbut 2004). In Woods’ retainer model, patients sign up for a one-year contract for unlimited appointments and X-ray services at his clinic for a monthly fee. He then directs them to an insurance company to obtain individual policies for services that Woods does not offer such as hospitalization, pharmaceuticals, and specialty care. Woods says his model “will get health insurance out of primary care” while state regulators are trying to ascertain if his practice meets the legal definition of prepaid medical services (Norbut 2004). Andrew Carroll, a family physician<sup>600</sup> in Arizona, argues, “My personal opinion on retainer practices is they’re just another form of insurance” (Norbut 2003). In the state of Washington, the Office of the Insurance Commissioner has issued two “technical assistance advisories, similar to informal letters of opinion” that are pertinent to retainer practices. One addresses the legality of extra fees charged by physicians who have participating provider contracts with health carriers and the other “warns about practices that charge fixed, periodic fees for services, regardless of whether services are rendered” (Vogt 2003). These arrangements may be illegal because “they ‘in essence, are insurance agreements’ and would require the practice to be registered as a health care service contractor or health maintenance organization” (Vogt 2003). So, another gloss on the trend of some

physicians attempting to exit managed care by opening boutique practices is to note a trend of some physicians reinventing themselves as a version of the HMOs and insurance carriers that they so vociferously rail against.

In summary, the logic of luxury medicine is to provide highly profitable medical services to a target audience of those who have large amounts of disposable income and healthy appetites for status affirmation. Given overwhelming evidence about better morbidity and mortality data associated with higher ranks in social hierarchies (Marmot and Wilkinson 1999; Evans, Barer, and Marmor 1994), these are exactly the people who have a lower probability of requiring intensive medical intervention from the perspective of medical necessity. Boutique medicine generates medical “need” among the relatively healthy even as it decreases access to medical services for those who are sicker and poorer. This “brain drain” to the healthy and affluent mirrors the systemic inequities built into the logic of private medicine and private insurance more generally.<sup>601</sup> A ratcheting up of what is considered to be the community standard of medical care for the wealthy generates greater demand for this version of personalized service among the middle class even as the poor and working class fall further behind in having their basic health care needs addressed.

#### Gaming the System: Fees, Fraud, and Specialty Hospitals

“Gaming the system,” a metaphor discussed in Chapter Four as a description of Enron’s manipulation of energy prices in California (McLean and Elkind 2003: 264-283), has also been used to describe the creative<sup>602</sup> ways that physicians act to indirectly control resources by “tactics such as ‘fudging’ that exploit resource rules’ ambiguity and flexibility to bypass the rules while ostensibly honoring them” (Morreim 1991: 443).

A random, national sample<sup>603</sup> of practicing physicians found “a sizeable minority” (39%) who reported using at least one tactic of 1) exaggerating the severity of

patients' conditions; 2) changing patients' billing diagnoses; and/or 3) reporting signs or symptoms that patients did not have in order to help patients secure coverage for needed care in the previous year (Wynia et al. 2000: 1858). Over a quarter (28.5%) of the physicians in this survey agreed with the statement that "today it is necessary to game the system to provide high quality care" but only 15.3% agreed "in general, it is ethical to game the system for your patients' benefit" (Wynia et al. 2000: 1862). Of those who reported using "manipulative covert advocacy tactics," 54% reported doing so more often now than five years ago (Wynia et al. 2000: 1858). More than a third of the physicians (37%) reported that their patients sometimes, often, or very often requested that they deceive third-party payers to help them obtain coverage for services in the last year (Wynia et al. 2000: 1862). It is anticipated that greater utilization restrictions within the health care system are likely to increase gaming tactics (Wynia et al. 2000: 1858) as are physicians' feelings of being pressed for time<sup>604</sup> (Wynia et al. 2000: 1864; Werner et al. 2002: 1138). The following section will move from gaming the system in the interest of patients to a discussion of practices that are arguably more self-serving: fees, fraud, and facilities such as specialty hospitals.

Retainer practices are on the borderline<sup>605</sup> of a trend toward charging fees to patients to access care. "A small but growing number of physicians across the country have instituted monthly or annual 'administrative' or 'access' fees to cover a variety of services that, in their view, they're not being reimbursed for by insurance companies" (Terry 2004). These fees, "ranging from \$50 to a few hundred dollars a year" are opposed by insurance companies and supported by medical societies (Terry 2004). One family practice physician, Albert Weisbrot, who has collected \$65,000 in administrative fees<sup>606</sup> from January to April 2004, "insists that he's not doing this to make more money. 'It's necessary to survive in this practice and give patients the same service'" (Terry 2004). Attributing "doctors' decisions to charge access fees as an ethical reaction to an

unjust compensation system,” medical societies “strongly support doctors who charge administrative fees:”

“What physicians have to sell is their time,” says Paul L. Kitchen, executive vice president of the Medical Society of Virginia. “The traditional practice of answering phone calls, doing prescriptions over the phone, and little consults here and there—they just can’t afford to that for free anymore” (Terry 2004).

Some physicians are testing to see whether they may impose “liability surcharges” to offset malpractice insurance costs (Romano 2004b). While some may be “similar to typical copayments of \$10 or \$15 per visit,” Physicians for Women’s Health, a 150-member OB/GYN group practice in Connecticut, has “announced it will charge an extra \$500 per pregnancy starting Sept. 1” (Romano 2004b). This announcement prompted a “consumer warning” from Connecticut Attorney General Richard Blumenthal urging “any pregnant woman assessed the fee to contact his office because ‘It is most likely illegal’” (Romano 2004b). Some physicians see the use of “liability surcharges” as a way of getting the public personally interested in tort reform. William Huffaker, a St. Louis plastic surgeon, said: “I see (surcharges) as a way to make this a patient’s problem” (Romano 2004b). Other physicians, such as neurologist Sheldon Gross from San Antonio, worry that surcharges “would make people think we are using the malpractice crisis as another way to increase fees. I’m concerned this would backfire” (Romano 2004b). Meanwhile, the American Medical Association voted in June 2004 to launch “a detailed study” of surcharges to see whether they can withstand “legal and regulatory challenges” (Romano 2004b). This topic of extra-billing as both exit from the insurance framework and as voice mechanism to advance their preferred outcome on tort reform will be revisited later in this chapter.

Fraud is used to refer generally “to intentional acts of deception that are designed to fleece a victim” (Kalb 1999: 1163). Three types of conduct that are often included in discussions of health care fraud are false claims, kickbacks, and self-referrals

(Kalb 1999: 1163). In addition to false claims such as misrepresentation of professional credentials as just discussed in Chapter Seven, misconduct in medical research is also a topical issue. Convincing evidence of under-reporting and suggestions of increased detection make the “true incidence” of misconduct<sup>607</sup> in medical research unknown (Breen 2003: 186). Breen’s argument that “risks to research participants may also be increasing, with increased pressure on researchers to publish and to produce commercialization of their research” (2003: 186) is congruent with illustrations presented in Chapter Five of physicians’ complicity with the pharmaceutical industry as the “Arthur Andersens of Medicine.”

Given the cultural context of market fundamentalism described in Chapter Four, it is not surprising that the health care industry often negotiates a fine line between “aggressive” business practices and fraud. Three illustrative but not exhaustive examples are HealthSouth, HCA, and Tenet. HealthSouth<sup>608</sup> overstated its earnings by at least \$1.4 billion from 1999 to mid-2002 and inflated the value of its assets by \$800 million. This prompted the Securities and Exchange Commission to say, “This case ranks up there with the likes of Enron and WorldCom” (Hellander 2003: 840). A forensic audit of HealthSouth found additional fraudulent<sup>609</sup> entries that raised the government’s 2003 estimate of fraud from \$3.5 billion up to range of between \$3.8 billion and \$4.6 billion (Freudenheim 2004).

The founder and chief executive officer of HealthSouth, Richard Scrushy, was indicted on 85 charges and faces stiff penalties under the Sarbanes-Oxley Act of 2002. If convicted, Scrushy “faces a possible maximum sentence of 650 years in prison, the forfeiture of \$279 million and more than \$36 million in fines” (Piotrowski 2003). Scrushy maintains, “I am an innocent man”<sup>610</sup> (Piotrowski 2003) in much the same way that Kenneth Lay explains, “I take full responsibility for what happened at Enron. But saying that, I know in my mind that I did nothing criminal” (Eichenwald 2004a). Richard Wade,

spokesperson for the American Hospital Association, said of HealthSouth's massive fraud "while deeply embarrassing for the healthcare industry, was carried out by a select few. 'This is about the egregious behavior of a handful of people at the top of an organization'" (Piotrowski 2003). Larry Sanders, chairperson of the American College of Healthcare Executives "and a leading industry proponent of ethics and good governance," said:

"Of course, this is not a healthcare issue," he said. "This is a financial issue, a corporate issue. I don't read this as anything negative about the provision of healthcare. The unfortunate thing for healthcare is that it happens to be a healthcare company. I'm just sorry that healthcare has to be tainted by the potential wrongdoing of a couple of people" (Romano 2003).

Another similarity that HealthSouth shares with Enron is allegations that outside auditors<sup>611</sup> and investment bankers "knew of fraudulent accounting practices at the company long before financial problems came to light" (Morgenson and Abelson 2004).

HCA is of interest not only as the largest for-profit hospital chain in the United States but also for its ties to Senate Majority Leader, Dr. Bill Frist. HCA settled its Medicare fraud charges with the government for a total of \$1.7 billion in civil and criminal penalties, which is "by far the largest amount ever secured by federal prosecutors" (Hellander 2003: 841). Examples of false claims related to HCA include:

HCA has also agreed to plead guilty to 14 felonies. These settlements end a seven-year investigation by the U.S. Justice Department of Columbia-HCA for intentionally overcharging Medicare by inflating the seriousness of diagnoses; keeping a second set of (inflated) Medicare cost reports; conspiring with the wound-care firm Curative Health Services (which operates out of HCA hospitals) to bill Medicare for management fees and marketing expenses not eligible for reimbursement; submitting claims for home care not eligible for reimbursement; and kickbacks for physician referrals (Hellander 2003: 841).

HCA, which has more than 200 hospitals and surgical centers in 23 states (Bivins 2003), changed its name from Columbia/HCA Healthcare Corporation in 2000 after three years of negative headlines. The name change helped HCA revert back to its roots as Hospital Corporation of America, one of the first for-profit chains, and served as a

“debranding” mechanism as “Columbia—the name and company—became almost synonymous with an aggressive health-care culture which had led to the fraud scandal” (Lagnado 2000). Gary Rosenberg, senior vice president of Mt. Sinai NYU Health, explains, “changing one’s name enables a hospital ‘to get rid of the bad part, the part that you are not most proud of, and that has put a pall over your brand’” (Lagnado 2000).

HCA was founded by Senator Frist’s father and brother. Frist, who “acknowledges that he brings a pro-market mindset to the table” is interested in “curbing medical malpractice lawsuits and reforming Medicare” (Bivins 2003). A California-based consumer advocacy group, the Foundation for Taxpayer and Consumer Rights, asked Frist to recuse himself from malpractice reform legislation that Frist supported that would set limits on noneconomic damages at \$250,000. The advocacy group cites as conflict of interest “the more than \$25 million in HCA stock owned by Frist’s immediate family as well as the \$260 million in malpractice premiums written by Health Care Indemnity, a subsidiary of HCA” (Group Questions Frist’s HCA Ties Amid Debate Over Tort Reform 2003).<sup>612</sup> Frist’s position is that:

I have never worked for HCA. I’ve never been on the board. I have had substantial stock holdings. I have put this in a blind trust. It really doesn’t influence the decisions I make in the United States Senate (Bloomberg News 2003).

HCA spokesperson, Jeff Prescott, said:

“We intentionally do not—in any respect—lobby the senator,” Prescott said. “For obvious reasons, it puts him in a compromising position, and we just think it’s inappropriate. We don’t do it. We don’t allow people who represent us to do it. It’s a stone cold rule (Bivins 2003).

“Other congressional leaders and government officials are fair game” for HCA; in fact, according to Prescott, “we are the largest hospital provider company and quite frankly we think it would be a disservice for us not to be involved in the discussion on issues of health care” (Bivins 2003). “We follow the Medicare stuff pretty closely, obviously,” Prescott said. “About 40 percent of our revenues come from Medicare” (Bivins 2003). Since 1990, HCA’s political action committee has contributed more than \$600,000 to both political parties and since 1997, HCA has paid \$1.1 million to the lobbying firm Smith-Free Group (Bivins 2003).



The for-profit hospital chain, Tenet, used to be called National Medical Enterprises before it was debranded (Lagnado 2000). In the early 1990's, National Medical Enterprises, which was the largest operator of psychiatric hospitals in the United States, was convicted of "paying kickbacks and bribes for referrals, and holding patients against their will until their insurance ran out" (Hellander 2003: 842). The company paid fines and settlements of nearly \$1 billion and plead guilty to seven federal charges (Hellander 2003: 842). Tenet is the subject of four separate federal investigations and private insurers are also investigating Tenet claims for overpayment.<sup>613</sup> Two of the investigations are with the Justice Department. The first involves investigating inflated "outlier"<sup>614</sup> payments that Tenet collected from Medicare and the second is a suit for up to \$500 million in damages for filing false Medicare claims between 1992 and 1998. The Securities and Exchange Commission is looking into charges of insider trading and a sudden drop in the company's stock price. The fourth is a Federal Bureau of Investigation case involving charges of unnecessary heart surgery at one or more Tenet hospitals (Hellander 2003: 842).

The last investigation centers on Redding Medical Center's cardiology program and two physicians, Chae Hyun Moon,<sup>615</sup> the chief cardiologist, and Fidel Realyvasquez, a cardiac surgeon. Moon "collected more from Medicare than all but one other cardiologist in Northern California" in that he had billings for almost \$4 million in the 12 months ending June 30, 2002 (Eichenwald 2003). Redding Medical Center helped to generate demand for cardiac services by using an "advertising campaign, with mailings and billboards that used tombstones and other images invoking death to persuade Redding residents to be checked for heart disease" (Eichenwald 2003). When an internist, Dr. Campbell,<sup>616</sup> complained to Redding administrators that his patients were undergoing unnecessary open-heart surgery, he was told to "mind his own business" (Eichenwald 2003). In addition to Dr. Campbell, more than six other physicians, as well

as medical technicians and patients expressed concerns to multiple administrators but “the hospital never conducted the peer reviews<sup>617</sup> that might have confirmed the critics’ doubts” (Eichenwald 2003). A number of patients who discovered that the surgeries that they were urged to have were unnecessary when reviewed by second and third opinions contacted the Federal Bureau of Investigation and filed lawsuits.<sup>618</sup> Although litigation and deaths finally provoked action, the evidence was there on the spreadsheets for any that cared to look:

Indeed, the numbers at Redding raise questions about how problems at the hospital could have been missed. The state filings show, in the 12 months ended June 30, 2002, Redding Medical Center generated pretax net income of \$94 million, more than any other of Tenet's 40 hospitals in California. Just down the street, the larger Mercy Medical Center reported pretax net income of about \$5 million in the same period. "When those types of numbers get reported back to the home office, does everyone stay willfully blind and declare a holiday, or does someone say, 'Let's postpone the celebration and take a hard look at these,' " said Neil Getnick of Getnick & Getnick, which specializes in business integrity counseling. "Part of business integrity is creating reasonable expectations amongst shareholders of what kind of profits you can achieve, and what we have seen with Tenet indicates that the company departed from that basic model" (Eichenwald 2003).

Tenet settled with the government for \$54 million to resolve the accusation of “unnecessary heart procedures and operations on hundreds of healthy patients,” which was “the largest ever for accusations of billing federal health program for unnecessary care.” Tenet did not admit to any wrong doing and the settlement ensured that company would not face criminal charges (Eichenwald 2003).

An editorial in the *Wall Street Journal* suggested that “the real Tenet scandal” was that “Tenet has done a disservice to one group: its shareholders” (The Real Tenet Scandal 2002). According to this perspective, gaming the system is normal and goosing Medicare is problematic only if you run into regulatory difficulty:

Health-care providers have been gaming Medicare since that federal insurance program evolved into a system of Soviet-style price controls in the 1980's. Medicare pays a fixed amount for a treatment, regardless of costs, and in turn companies search for loopholes in the system's 100,000

pages of regulations to make up the difference....None of this is illegal; Tenet has the right to raise its charges and benefited from a Medicare formula that rewarded it for doing so. Nor is Tenet an isolated case. The company was among the most aggressive in raising charges, but dozens of other hospitals have also goosed the system in the same way. We're told that Tenet came under regulatory scrutiny only when competitors, worried they weren't getting their fair share of outliers, snitched (The Real Tenet Scandal 2002).

If market forces were left unfettered<sup>619</sup> from regulatory interference, then what was purported to be scandal would be recognized as the laudable "aggressive pricing strategy" that it really was. The real scandal was that "Tenet's earnings growth and rocketing share price were driven by outlier payments that were bound to end sooner or later, yet shareholders weren't let in on the secret" (The Real Tenet Scandal 2002). The one sentence comment on the unnecessary and harmful cardiac interventions at Redding Medical Center was it "suggests a corporate culture that was too aggressive for its own good" (The Real Tenet Scandal 2002). The perpetual orientation in this culture of market fundamentalism is individual interest over collective public goods or capacity for empathy.

It is fascinating to note that the exact extent<sup>620</sup> and nature of Medicaid crimes is as uncertain as the larger fraud situation<sup>621</sup> so that it is the more bizarre anecdotal instances of fraud against Medicaid that tend to linger in one's imagination. Physicians billing Medicaid for services on persons who were already dead at the time services were alleged provided, or billing for abortions on women who were not pregnant,<sup>622</sup> or billing for 4,800 hours in the year, or almost 24 hours each workday stand out as illustrative examples (Jesilow, Geis, and Pontell 1991: 3319). Reminiscent of slang used by house officers, income generation tactics under fee-for-service reimbursement programs have generated its own nomenclature that includes such terms as "*pingponging* (sending patients back and forth for unnecessary visits); *family ganging* (examining all members of

the family in one visit); and *churning* (mandating unnecessary visits) (Jesilow, Geis, and Pontell 1991: 3318).

Interviews with 42 physicians who had been sanctioned in New York and California for Medicaid fraud or abuse<sup>623</sup> revealed “the almost ubiquitous unwillingness of members of the sample to indicate greed as the root cause of their difficulties” (Jesilow, Geis, and Pontell 1991: 3320). Researchers who conducted this qualitative study were struck by the “intensity of their defenses of what they had done:”

At the most, the physicians we interviewed might acknowledge that they had been a little careless, but this was said to have been because they were fundamentally trusting people, more interested in the welfare of others than their own salvation, and that this character flaw had stood them in ill stead. The physicians typically saw themselves as sacrificial lambs hung out to dry because of incompetent or backstabbing employees, stupid laws, bureaucratic nonsense, and a host of similar reasons (Jesilow, Geis, and Pontell 1991: 3320).

Paul Jesilow and his colleagues (1991: 3321) argue that the “subculture of medical delinquency” flourishes “because of the tension between regulation and professional norms.” One of the physician respondents describes the Medicaid program using a logic that is quite analogous to both “teaching medical students to lie” and the “real Tenet scandal:”

One of the peculiarities that they do is that they make arbitrary decisions about things totally unrelated to the services you provide. They’re constantly irritating and aggravating the doctors and their staff. I could keep you here the rest of the day giving you examples of their kind of idiocy, that they somehow manage to make sense out of in their little peculiar world that’s unrelated to ours. They’ve built in systems that either ask for somebody to cheat, you know, or to cheat the patient on the type of care that’s provided. You put somebody in the position where lying is the most reasonable course, and they will lie. The patients will lie; the doctor may even lie on what they say about what happened (Jesilow, Geis, and Pontell 1991: 3321).

Interviewed officials from the Medicaid program “were particularly irked by what they saw as high-minded explanations for low-spirited behavior” (Jesilow, Geis, and Pontell 1991: 3321). The physicians that were interviewed failed to recognize “a

significant gap between their explanations of the considerable shortcomings of Medicaid and the treachery of patients and employees and the blatant and self-evident nature of the violations for which they often had been sanctioned” (Jesilow, Geis, and Pontell 1991: 3321).

Opprobrious comments directed by a representative of the American Medical Association against the few bad apples “who would serve themselves at the expense of others” (Todd 1991: 3338) in the context of Medicaid fraud may be juxtaposed with “Physician Referral—the AMA View” (Todd and Horan 1989). The Inspector General of Health and Human Services, Richard Kusserow, issued a report in 1989 that showed “physician-entrepreneurs who owned or invested in freestanding clinical laboratories ordered 45 percent more lab work for Medicare patients than did physicians with no such investments” (Weiss 1997: 42). These “excessive lab tests” (Weiss 1997: 42) or “this increased level of service” (Todd and Horan 1989: 395) cost the Medicare program an extra \$28 million in 1987. Instead of viewing this as another potential instance of the few serving themselves at the expense of others, Todd and Horan defend quantity as a higher quality of care. “Many of these ‘additional’ services may be a consequence of the increased availability of laboratory services and may represent a higher standard of care for these Medicare patients” (Todd and Horan 1989: 395).

The scope of physician investment in commercial enterprises from which they might benefit is difficult to ascertain and is probably underreported.<sup>624</sup> Investment categories may be divided into those provided within the physician’s office and those facilities that are separated from the primary practice location. Office based technology may include laboratory services, radiological imaging, ultrasound evaluations, electrocardiography, and stress testing. Services or facilities separated from the group or individual’s primary office could include diagnostic services,<sup>625</sup> therapeutic services,<sup>626</sup> home health agencies, nursing homes, outpatient infusion therapy services, and

suppliers of durable medical equipment (Zientek 2003: 114). Arguments<sup>627</sup> both for and against physician investment and self-referral are often organized around the themes of cost, quality, and access to services so common to general health care reform discourse. In their barest forms, advocates of physician investment argue that quality, cost, and access are improved when “arrangements encourage competition and allow physicians, rather than nonphysician investors, to maintain control over medical services” (McDowell 1989: 62). Critics suggest quality, cost, and access are threatened when physician self referral arrangements “encourage over-utilization of medical services and create a damaging conflict of interest for physicians” (McDowell 1989: 62).

A number of studies show that utilization rates and costs for diagnostic services increase when physicians self refer although doubts persist about whether patients are being over-treated or under-treated.<sup>628</sup> The American Medical Association’s<sup>629</sup> official stance on physician self-referral was supportive<sup>630</sup> or non-prohibitive<sup>631</sup> within specific guidelines until 1991 (Moore 2003: 135) while other professional groups, such as the American College of Radiology, stated in 1989 that such arrangements should be prohibited<sup>632</sup> (McDowell 1989: 81). Nancy Moore makes the important point that the federal “government’s ever-increasing role in regulating physician conduct is a response to the profession’s own failure to adequately deal with conflict of interest problems” (2003: 134).

Specialty hospitals, mirroring boutique physician care, are the latest illustration of physician practices to come into the federal spotlight as potentially self-serving. The 92<sup>633</sup> specialty hospitals that provide niche services (cardiac, orthopedic, surgical, and women’s hospitals) as of February 2003 account for less than 2 percent of the short-term, acute-care hospital beds nationwide but the number of such facilities have tripled since 1990 (General Accounting Office 2003: 3). Approximately 70 percent of the specialty hospitals under development or in existence had some physician owners; total physician

ownership averaged slightly more than 50 percent among these hospitals (General Accounting Office 2003: 4). In 21 out of 25 specialty hospitals it was found that the specialty hospitals treated lower proportions of patients of severely ill patients compared with general hospitals in their geographic areas (General Accounting Office 2003).

Many of the dynamics of concern and rhetoric about specialty hospitals are reminiscent of earlier discussions of boutique medical practices. As surgical admissions are more profitable than medical admissions and as certain surgical procedures (such as cardiovascular and orthopedic) are among the most profitable, boutique hospitals have relatively high profit margins (Devers, Brewster, and Ginsburg 2003: 1). "Concerns have been raised by general hospitals and others in the health care community that specialty hospitals are siphoning off the most financially rewarding portions of general hospitals' business" (General Accounting Office 2003: 1). Metaphors of specialty hospitals as "cream skimmers" (Devers, Brewster, and Ginsburg 2003) engaged in "poaching of services"<sup>634</sup> (Jaklevic 2003a) and "cherry picking"<sup>635</sup> (Hawryluk 2003) are common. Critics of boutique hospitals say that "when you have physician ownership, there is an economic incentive for them to send well-insured patients to specialty hospitals"<sup>636</sup> (Reilly 2003). Community hospitals depend on "profitable patients" to provide the volume needed to cross-subsidize other basic services; cardiology services, for example, can account for 25 percent of all hospital stays but 35 per cent or more of community hospitals' revenue (Devers, Brewster, and Ginsburg 2003: 2). Specialty hospitals caring for the relatively healthy and wealthy are additionally charged with "shirk(ing) the burden of providing emergency care" (Abelson 2003).<sup>637</sup>

A report from the Center for Studying Health System change notes that in addition to relatively high reimbursement rates for some procedures and specialists' desire to increase their income "in the face of reduced reimbursement for professional

services,” other important drivers of the specialty hospital trend are physicians’ desire for greater control over management decisions affecting quality and productivity (Devers, Brewster, and Ginsburg 2003: 1). Dennis Kelly, spokesperson for MedCath Corp., a for-profit chain of specialty heart hospitals, argued new regulations on specialty hospitals are not needed because “the primary driver is patient care and the ability of physicians to be more in control of the hospital environment—not pure economic concerns” (Manning 2003). Randy Fenninger, the lobbyist for American Surgical Hospitals Association, which represented 50 specialty hospitals, says “doctors go to these systems because of the high quality of care for their patients and the efficiency is very high. Most doctors say they can do twice as much work. We are not cherry picking” (Reilly 2003).

What is common to boutique hospitals and boutique medical practices is that quality care for the healthy and wealthy is privileged over universal care that might assist those most in need of medical care. The ethical and legal borderlands between fraud/abuse and aggressive, entrepreneurial activities in the health care industry, within luxury practices, and as physicians ponder extra-billing are often liminal and contested spaces. While most physicians are not the few bad apples, the occasional horror story serves as a synecdochical reminder of the power that doctors wield among people who may be particularly vulnerable. It is not every occupation,<sup>638</sup> for example, that has the opportunity to convince a person with the intellectual capacity of a 12 year old that having sex with the physician is a medical treatment and then has the capacity to bill the Oregon Health Plan for multiple therapeutic encounters<sup>639</sup> (Tomlinson 2004). “Gaming the system” by physicians may be considered to be pragmatic means to achieve desired ends for patients and/or physicians but this tactic comes with its own cost. In addition to potential harm to actual patients (quality issues), actual harm to potential patients (access issues), fueling infinite demand in a context of finite resources (cost issues), eroding scientific, evidence



based decision criteria (issue of professionalism), and dissipating public trust in the fiduciary relationship (issue of professionalism), gamesmanship has also eroded intergenerational solidarity among physicians. Younger cohorts of physicians speak bitterly of “physicians (who) really raped the system” and how “my generation is now paying for some of the excesses of the previous physicians” (Dosik 1993: 133). While the implications of gaming for both the profession of medicine and the common weal are difficult to understate, it is also important to be ever mindful of a milieu of market fundamentalism as cultural context. Medicare patients who frequently access medical services in Florida have been accused of misusing resources even as Floridian patients have accused physicians of wasting resources by “raping Medicare”<sup>640</sup> (Kolata 2003). Metaphors of doctors and patients abusing the system highlight a cultural predilection to focus on individual behaviors rather than a dysfunctional system that makes a specific behavior seem possible, desirable, or even needful.

Voices for Health Care Reform: Organizing Labor, Protesting for Tort Reform, and Shilling for the Market

You can actively flee, then, and you can actively stay put.  
Erik Erikson (Hirschman 1970: 49)

Voice has been defined by Hirschman as “any attempt at all to change, rather than to escape from, an objectionable state of affairs” or “nothing but a basic portion and function of any political system, known sometimes as ‘interest articulation’” (1970: 30). Petition for change may be individual or collective and often involves actions and protests designed to mobilize public opinion. Voice may be used when the exit option is unavailable or comes at too dear a price (Hirschman 1970: 33), voice may be an alternative to exit (Hirschman 1970: 37), and voice may be combined with threats of exit. Indeed, “if voice is to be at its most effective, the threat of exit must be credible, particularly when it most counts” (Hirschman 1970: 85). While an earlier section of this

chapter was concerned with physicians' exit from an understanding of health care as a public good as the system was gamed, the following section will consider how organized medicine advances its interests through voice, often backed up by exit.

#### Physicians for Responsible Negotiation, A Union that Dare Not Speak Its Name

As with so many topics in this dissertation, there is a robust literature on labor organizing by physicians<sup>641</sup> that this discussion does not intend to replicate. In the interests of space, this dissertation will also forgo a detailed consideration of the labor movement to unionize house staff, except to note that advocacy by the Association of Internes and Medical Students for national health insurance provoked charges of a "communist front" by the American Medical Association in the late 1940's.<sup>642</sup> While collective action by house officers fits easily into a politics of oppressed workers seeking redress for its grievances, the dynamics of labor action among an occupational group that prides itself both for its professional and entrepreneurial characteristics are a bit more puzzling. Not so long after the Interne Council of Greater New York was formed in 1934, the Kings County Physicians Guild was formed in 1941 (Budrys 1997: 118). There was a flurry of physician union activity in the early 1970's but of the 26 unions that emerged during that time period, only the Union of American Physicians and Dentists survived (Budrys 1997: 16). A "changing health care environment," which is usually code for the rise of managed care, is often given as an explanation for a renaissance of interest in collective bargaining and unionization in the 1990's. "A growing number of physicians have begun to see formal unionization as a valid and effective response to managed care" (Luepke 1999: 277). While the ascent of physician unionization is certainly congruent with more physicians working as employees and with doctors' eloquent expressions of dissatisfaction as discussed in earlier chapters, only about 45,000 of the 650,000 active physicians in the United States are union

members (Romano 2001). We might then pose the question in 2004: why are most physicians not currently unionized in the United States? Or, at the very least, why aren't they humming the AMA Union Organizing Song, National Public Radio's "gift to medical trade unionism" to inspire the rank and file?

The larger cultural context, of course, is that the proportion of union members in the total nonfarm workforce declined from 32.5% in 1953 to 17.5% in 1986 in the United States (Moody 1988: 4). Deindustrialization as manufacturing jobs have continued to be outsourced to areas that have cheaper labor and less regulatory oversight (as discussed in Chapter Four) has contributed to the continuing fall in union membership. The percentage of wage and salary workers who were union members declined from 13.3% in 2002 to 12.9% in 2003 (Bureau of Labor Statistics).

Although physicians who are employees "may be able to avoid antitrust problems because they are eligible for protection under the National Labor Relations Act" (Erf 1999: 96), a "physician union may be an antitrust mine field" (Hoffman 1998: 81). This complicated legal situation depends on a framework that draws distinctions between private and public sector employment and whether an individual has status as an independent contractor or as an employee (Erf 1999: 97). "The core problem is that there is a conflict between the goals of the antitrust laws and those of the labor laws"<sup>643</sup> (Hirshfeld 1999: 45). This leads to the dilemma of contested interpretations of whether specific behaviors in particular contexts are really collective bargaining activities of solidarity or price-fixing gambits that are illegal.<sup>644</sup>

Although about 250 physicians signed cards in New Jersey to join the United Food and Commercial Workers International Union, which perhaps has more experience organizing supermarket employees than doctors <sup>645</sup> (Whitford 1997; Huff 1998), there are five multi-state physician unions that are significant. Four of these are indirectly affiliated with the AFL-CIO (National Doctors Alliance,<sup>646</sup> Federation of

Physicians and Dentists,<sup>647</sup> Union of American Physicians and Dentists,<sup>648</sup> and the National Guild for Medical Professionals<sup>649</sup>) and the fifth is the American Medical Association's Physicians for Responsible Negotiation (PRN)<sup>650</sup> (Preston 2000).

PRN is of particular interest as it can be perceived as an organization that was arguably doomed or even structured to fail. After a history of "vigorous opposition to physician unions" based on a conviction that "unionization is inappropriate for such a high-status occupation as that of physicians" (Budrys 1997: 17), the American Medical Association announced the formation of an "affiliated national labor organization" in June 1999 (Smoak). The formation of PRN was presaged by an easing of AMA opposition to physician collective bargaining in 1993 as they tried to "educate physicians on managed care issues" (Phan 1999: 136). The AMA House of Delegates moved beyond education when they passed a resolution in 1997 "directing the AMA to draft legislation to allow self-employed physicians to form collective bargaining units to bargain with managed care companies" (Phan 1999: 136). According to an April 1999 AMA poll, 68% of their membership wanted the AMA to form a union but the AMA Board of Trustees recommended against it (The Amalgamated Doctors of America 1999). "The subject is so contentious that the trustees buried the recommendation against an AMA union deep in the report—and didn't mention it in their executive summary" (The Amalgamated Doctors of America 1999). Trustees felt that they were in a no-win situation in that "anti-trust law blocks the self-employed from joining unions" which would limit a union's effectiveness and the issue was so polarized that a decision either way would alienate a sizeable amount of their declining membership (The Amalgamated Doctors of America 1999).

When a majority of the 494 delegates voted to form a union, the AMA placed full page advertisements in several newspapers announcing: "Last Wednesday, we voted to put what's out-of-whack in healthcare back into whack" (Tschida 1999). Other physician union

leaders were delighted with the PRN announcement as it gave legitimacy to their *raison d'être* as Dr. Robert Weinmann,<sup>651</sup> president of the Union of American Physicians and Dentists, explained:

“The main thing is that the AMA has made a complete reversal of its 27-year mantra, during which it said, most pompously, that the AMA is not a union nor could it ever become one,” he says. “What they did do was lend their aura of respectability to this movement, which heretofore they had denigrated. This is helpful because it now means that doctors no longer have to worry about whether to join a union, they only need decide which union they’re going to join” (Tschida 1999).

The American Medical Association still had a difficult time with any kind of union identity in 2000. Dr. Todd Vande Hey, a member of PRN’s board said, “We don’t even like using the word ‘union’ in connection with PRN” (Preston 2000). In the press release announcing PRN, the emphasis was squarely on how PRN would help physicians “advocate more effectively on behalf of their patients:”

Our objective here is to give America’s physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits. By forming an affiliated labor organization, eligible physicians will be able to fight for quality patient care while remaining faithful to the AMA’s historic and unwavering commitment to ethics and professionalism. No other organization can make that promise to the patients of America—and keep it (Smoak).

It is interesting to note that in 1972 the Preamble to the Union of American Physicians and Dentists’ organizing charter also transformed the umbrage articulated in Chapter Seven by Dr. Marcus into operational terms of quality “for the welfare of their patients:”

We physicians and dentists, in order to provide optimum medical care for people; to insure quality facilities for the provisions of medical care; to enable doctors to give of themselves, unhindered by extraneous forces, for the welfare of their patients; to insure reasonable compensation for doctors commensurate with their training, skill and the responsibility they bear for the life and health of their fellow beings; do establish this Union (Budrys 1997: 9)

The unequivocal position taken by PRN is that their physicians will never strike. Ross Rubin, executive director of PRN, said, “Doctors shouldn’t strike, so they won’t strike. I don’t think it puts us at a disadvantage at all. We’ll be negotiating from a

professional platform” (Thompson 2000a). This differs sharply from the perspective of physician union advocates who argue that:

..strikes are the ultimate collective bargaining tool. If those with whom you are bargaining know you would never invoke a strike, you deal from a position of weakness. In the opinion of Robert L. Weinmann, president of the Union of American Physicians and Dentists president, “If you’ve given away your best weapon, you’re like a general who says in advance he won’t use ground troops” (Goodman 1999).

PRN, the labor organization that dares not speak the name of union, pitches in Exhibit 8.1 that from their elevated professional perspective, unsullied by solidarity with other lesser labor life-forms, that they are the only ones who can conduct themselves as professionals with a modicum of care for patients:

**Exhibit 8.1 Comparison of Physicians for Responsible Negotiation vs. Traditional Labor Organization with Physician Membership as Articulated by PRN\***

Category/ Activity	PRN	Traditional Union
Membership	MDs and DOs only	Professional, skilled, and unskilled workers
Board of Directors	Selected by AMA	Elected by delegates from locals
Affiliation with other labor groups/professions/vocations	no	yes
Commitment to quality patient care	Quality of care may not be sacrificed in lieu of physician interests	May have quality of care statement in constitution
Work/ organized in conjunction with state, country & medical specialty societies	yes	Generally no. CIR has forged a membership agreement with the California Medical Association
Goals of organization: Represent physician interests	yes	yes
Represents patient interests	yes	some
Organizational growth Actively solicits formation of new local unit (increase dues base)	Not necessarily, advertises availability but will only begin discussions by invitation	yes
Offers alternatives to membership in labor org	Yes, encourages it	no
Membership required as condition of employment (closed shop)	no	most
Subscribe to AMA Code of Ethics and CEJA opinions	yes	no
Honor union picket lines	no	yes
Negotiation Tactics: Strikes/ withholding necessary medical services	no	Yes, but generally discouraged for physician units
Informational pickets and non-disruptive demonstrations	yes	yes
Lobbying and publicity campaigns	yes	yes
Provision of free medical service work	yes	no

\*Source: Physicians for Responsible Negotiation website, accessed August 21, 2004  
[http://www.4prn.org/union\\_tb.html](http://www.4prn.org/union_tb.html)

With policies of not seeking new members, restricting membership to an occupation group that “doesn’t use the U-word,”<sup>652</sup> and rejecting strikes or even credible threats of strikes, it is difficult to know what success would have looked like for PRN as a labor organization. The American Medical Association “quietly abandoned” Physicians for Responsible Negotiation after “spending at least \$3.6 million on an ill-fated venture that organized just 38 physicians in four years—a cost of about \$95,000 per physician” (Romano 2004a).<sup>653</sup>

Grace Budrys attributed the demise of the physician unions that failed since the early 1970’s as inability to overcome two main obstacles: charges that “unionization is inconsistent with medical professionalism and that the ultimate bargaining tool unions rely upon, the strike, is unacceptable” (Budrys 1997: 17). Medical professionalism can be code for not wanting to lose prestige and privilege by being associated with stereotypical blue-collar interests. Gary Newkirk, for example, argues against physician unions by citing his unwillingness to be identified as an oppressed worker:

It’s hard to apply the notion of unions to our profession. Do physicians, whose incomes are in the top 2% of the nation (top 1% of the world’s!), really want their concerns for the quality of care they deliver to be equated for one second with the intolerable sweat-shop, child-labor conditions bred by turn of the century American industrialization? I don’t think so (Newkirk 1999).

After distancing himself from the underclasses, Newkirk concludes his article with a rhetorical appeal to nationalism and a tribute to idealized democracy:

...we are privileged to already be a member of one of the greatest unions this world has ever seen. It is called the United States, which is based upon the principles of a free democratic society. Each of us already has the most powerful tool of a union, namely the vote. We should make our views known and vote for representatives that empower us to do our jobs. In the meanwhile, when it comes to physician unions, I say that this emperor is buck naked (Newkirk 1999).

On the issue of strikes, it is ironic that PRN was so fixated on the presumption that potential risks to patients outweigh any possible benefits when calculating the



ethics of physician strikes. Although there certainly have been individual patients who have died during physician strikes,<sup>654</sup> there were between “55 to 153 deaths estimated to have not occurred as a result of the decrease in the number of surgeries performed during and because of the physician strike” in Los Angeles County in January 1976 (James 1979: 442). A strike of approximately 8,000 physicians in Israel from March 3, 1983 to June 26, 1983<sup>655</sup> generated heated debate on the ethical dilemmas of physicians’ striking (Grosskopf, Buchman, and Garty 1985). An examination of death certificates found no significant differences in mortality between a control period in 1982 and the strike period in 1983 (Slater and Ever-Hadani 1983). It was also shown during this specific strike that despite “drastic disturbances in organized perinatal care,” that there was no change in perinatal mortality or in Apgar scores (Bukovsky et al. 1985). A danger of striking as a tactic for physicians is the questions that it might provoke. Paul Slater and Prina Ever-Hadani (1983: 1306) write: “this [mortality] finding prompts us to ask how far primary care in Jerusalem contributes to the prevention of death and whether, in normal times, the primary care services in the city are excessive.”

#### Surgical Strikes Without Unions: Malpractice Activism, Sunshine Lists, and House Calls by the American Medical Association

If Physicians for Responsible Negotiation was a model of a “union” without strikes, this section considers strikes without unions or more generally, collective action by physicians not necessarily organized by a traditional labor organization. The point of departure for this discussion will be the American Medical Association’s “No. 1 legislative priority,”<sup>656</sup> which is not universal health insurance nor the 195,000 deaths per year in the United States attributable to preventable medical errors (HealthGrades 2004) but “medical liability reform.”

As with other illustrations throughout this dissertation, the issue of malpractice is complicated and its literature is ever voluminous. Without delving comprehensively into this topic, there are a few observations that may be made by considering how organized medicine talks about and acts out on this issue. As one might expect given their slogan of “physicians dedicated to the health of America,”<sup>657</sup> the issue of malpractice liability is consistently framed by the American Medical Association as a crisis that threatens access to care (2004:3), increases costs (2004: 4), and is “threatening health care quality for all Americans” (2004: 5). The American Medical Association’s website includes a lurid red and yellow map of the United States to graphically illustrate “America’s Medical Liability Crisis.” “Facts” as well as “debunking arguments” presented in *Medical Liability Reform—NOW!* (American Medical Association 2004) ripple out to the Doctors for Medical Liability Reform’s website to magnify the extent of the crisis:

Skyrocketing<sup>658</sup> medical liability insurance premiums are forcing doctors to limit services, retire early, or move their practice to a state with liability reforms in place, creating vast areas across America where patients no longer have access to critical healthcare services. The American Medical Association has identified 20 states currently experiencing an access-to-care crisis. Of the remaining states, 24 have the potential to be deemed “in crisis.” Only six states – California, Colorado, Indiana, Louisiana, New Mexico and Wisconsin – are considered stable; the common denominator is that all six have instituted some type of reform.<sup>659</sup>

After noting that extent of this malpractice “crisis” is hotly contested,<sup>660</sup> it might be helpful to consider the labels attached to “The 1975 Insurance Crisis” (Danzon 1985: 97), which in Los Angeles County was described as “the triad of medical malpractice, malpractice liability, and malpractice insurance coverage” (James 1979: 437), which previously precipitated collective action by physicians. The events of January 1976 in California have been variously described as a “boycott,” “militant trade union action,” (Sakmyster 1981: 99-101), “partial withdrawal of physician services,” “medical malpractice slowdown” and “physicians’ strike” (James 1979: 437). In the new

millennium, other illustrations of collective action by physicians, also in response to a "malpractice crisis,"<sup>661</sup> somehow fell short of being called a "strike":

Last summer, when almost all 67 surgeons at Las Vegas's only trauma center resigned, it closed for ten days. Last month, in West Virginia, surgeons at several hospitals walked off the job for a few days. And this week, more than 800 physicians around Palm Beach, Fla., stopped work for two days (Newman 2003).

A New Jersey physicians' strike for a week in February of 2003, in which 70 percent of the state's 22,000 physicians took part, was called, even within one newspaper account, "a protest," "limited walkout," and "work stoppage" (Peterson 2003). The semantics of avoiding the "strike" word to go along with the "union" word in an occupation that is worried about the appearance of professionalism is not incidental. A sympathetic account of the New Jersey "job action," in an article called "Malpractice: Close-Up on a Crisis" by a medical reporter who described herself as the wife of a New Jersey obstetrician, specifically mentioned that "everyone was careful to avoid the word "strike" (Weiss 2003: 26-28). The importance of strategically representing a particular perspective and set of interests in the description of an event becomes clearer as we read Charles Goodman's gloss on the distinction between a "lock out" and a strike:

When health care providers' salaries dwindle, their malpractice and medical licenses are placed in jeopardy, their best medical knowledge is ignored, and they must deal with Health Maintenance Organizations that act with impunity, they are virtually "locked out of practice." When this escalates to the point that care can no longer be provided, physicians must be permitted to close their doors. Some would mistakenly call that a strike (Goodman 1999).

What makes collective action by physicians unique is that the occupational services that are within their power to withhold can involve life and death. In the clash of Titans between organized medicine, governments, insurance companies, and managed care organizations, patients can be ground down. Or, as the New South Wales Minister for Health, Dr. Refshauge, said in the context of a dispute with Australian doctors, "patients are the meat in the sandwich" (Passey 1997). For that reason, some

physicians, such as Dr. Arthur Roth, refused to participate in the New Jersey strike by saying, "This is not a plumber's union. We are dealing with people's lives" (Stewart 2003). As with historical examples in Chapter Three, physicians in New Jersey tried to enlist their patients' support by bring the "crisis" to their attention by sending them letters explaining their office closure:

We are sorry to inform you that it will be necessary to reschedule your office visit on Monday, February 3, 2003. Our practice is participating in a statewide job action in which we and other physicians and surgeons are closing our practice. We do this to alert you to the fact that New Jersey is in a crisis over a failure of the governor and legislature to deal with the issues of medical malpractice (Buccino 2003).

The Medical Society of New Jersey also provided physicians with scripted messages<sup>662</sup> that they could leave on their answering machines encouraging patients<sup>663</sup> to contact their legislators via a special phone line "if you would like to support physicians and the future of health care in New Jersey." The softer face of this "job action" was Dr. Robert Rigolosi, president of the Medical Society of New Jersey, who explained:

We will continue to see emergency cases, we will continue to do deliveries of pregnant women but elective cases will not be seen, routine office visits will not be done, routing mammographies will not be done. They will not be done until we can get some meaningful reform (Peterson 2003).

The harsher face of this dispute recalls the scare tactics discussed in Chapter Three. One physician at Christ Hospital in Jersey City carried a sign that advised: "When your water breaks, call your lawyer" (Peterson 2003).

A resolution put forward at the American Medical Association meeting in June 2004, however, would have left some lawyers no one to call. A resolution put forth by a South Carolina surgeon, J. Chris Hawk, "representing an entirely new front in the doctors' ongoing battle with malpractice reform," seeks endorsement for "the right of doctors across the nation to refuse care to plaintiff's attorneys and their families" (One Doctor's Tort Reform: Stop Caring for the Lawyers 2004). Hawk says that "if doctors

refuse to care for trial lawyers and their families, then maybe they'll understand what it's like to be a patient who cannot find medical care" (Neighmond 2004). Hawk sent one of his patients, the wife of a trial attorney, a letter telling her that she should find another doctor. Dr. Hawk explains:

I feel like there's an adversarial situation that is created between plaintiff's attorneys and physicians so that I'm not sure that I can give them as good care as I could to a regular person. I don't want to be in that situation where I cannot offer my best to any patient, and therefore I choose not to treat them (Neighmond 2004).

Although Hawk's resolution was "angrily shouted down" at the American Medical Association meeting, a number of other physicians have also turned away patients. A New Hampshire neurosurgeon, Dr. Clinton "Rick" Miller, for example, told the president of the state's trial lawyers association that he would not perform elective surgery on him because the rejected patient lobbied against limits on malpractice lawsuits. Miller said, "If someone takes a position that is very deleterious to your welfare, you have a right not to do business with him" (Babwin 2004). Dr. Michael Kanosky, a plastic surgeon in Mississippi, refused to treat "the daughter<sup>664</sup> of a state lawmaker who opposed limits in damage lawsuits against physicians in the state" (Babwin 2004).

These few isolated incidents are more worrisome when combined with awareness of an "obscure Texas company run by doctors" that was operating a web site ([www.doctorsknowus.com](http://www.doctorsknowus.com)) which, compiled and posted "the names of plaintiffs, their lawyers and expert witnesses in malpractice lawsuits in Texas and beyond, regardless of the merit of the claim" (Blumenthal 2004a). For a fee, subscribers can search the database "one person at a time or monitor any sized group of individuals for litigious conduct." The website said, "They can sue but they can't hide" (Blumenthal 2004a). In this "first effort to use public sources to compile a list of litigants in 'predatory lawsuits' that are causing a medical crisis," there is no distinction made on the merits of the

cases<sup>665</sup> (Blumenthal 2004a). The American Medical Association “saw no ethical issue at stake” with this website. Both the American Medical Association<sup>666</sup> and the Texas Medical Association<sup>667</sup> commented that it reflected the frustration of physicians with the tort system (Blumenthal 2004a). This blacklist, which a consumer advocacy group named Texas Watch called “a mean-spirited database to deny access to medical care,” was closed down after five months in March 2004 (Blumenthal 2004b). A notice that was posted on the website when it closed said:

The controversy this site has sparked was unanticipated and has polarized opinions regarding the medical malpractice crisis. Our hope is that this controversy will spark a serious discussion that results in changes that are equitable to both patients and physicians (Blumenthal 2004b)

Dan Lambe of Texas Watch summarized this behavior as “an alarming trend in a kind of vigilante-style behavior for what appears to be an extremist group of doctors ... looking to punish innocent patients and their attorneys who help them exercise their constitutional rights” (Babwin 2004).

This vigilantism is not just directed towards patients and lawyers. Another resolution that was debated and defeated at the American Medical Association meeting called on the AMA to fund a national Internet listing of doctors who testify against other doctors in medical malpractice cases. In another example of sanitized language, Dennis Agliano, a physician from Florida, said during this debate: “this is not a blacklist; it’s a sunshine list” (Ethics Aren't So Instant After Group Hears From the Experts 2004). A different form of intimidation is peer review by medical associations and specialty associations that is alleged to be the medical profession’s “newest tactic to get rid of medical malpractice claims by intimidating expert witnesses” (Ellman 2004). With the support of the American Medical Association, the Florida Medical Association as well as other state and specialty medical associations have “activated a system to

track and punish physicians who provide allegedly fraudulent expert testimony against their colleagues, particularly those who work for plaintiffs” (Ellman 2004).

The last illustration of a boycott as a form of vigilantism is a tactic used by the Federation of Physicians and Dentists when it asked its 8,500 members to avoid prescribing pharmaceuticals manufactured by Merck & Co. (Hallam 2000). This boycott was generated as a response to a subsidiary, Merck-Medco Managed Care LLC’s membership in a coalition that was lobbying against federal legislation that would grant independent physicians an antitrust exemption. Jack Seddon, executive director of the Federation of Physicians and Dentists, said:

We never called for a “boycott.” We just put the word out to our members that they should look at this list (of coalition members) and reward their friends and punish their enemies (Hallam 2000).

Robert Leibenluft, legal counsel for the coalition, whose membership includes the American Nurses Association, American Association of Health Plans, Healthcare Leadership Council, and the U.S. Chamber of Commerce, argues:

This certainly seems to be a boycott. What it reflects are the kinds of concerns that people have about giving an antitrust exemption to physicians. The notion of switching over from drugs one would normally prescribe to something else raises some ethical questions (Hallam 2000).

Using a metaphor of terror that resonates in a post-September 11, 2001 context, American Medical Association President Yank Coble tried to mobilize AMA membership by warning: “as a profession, we are at war against a form of toxic tort terrorism” (Coble 2003). A coalition of 230,000 practicing medical specialists<sup>668</sup> have taken up this call to arms by forming Doctors for Medical Liability Reform (DMLR) which is “dedicated to protecting patients’ access to healthcare by promoting the passage of federal legislation to put a cap on non-economic damages awarded in medical liability cases.”<sup>669</sup> In the summer of 2004 this coalition “bought TV time in four states with US Senate races—Washington, North Carolina, South Carolina, and

Georgia—to air a 30-minute infomercial” (Jenkins 2004). Carrie Shaw of the Washington State Chapter of Doctors for Medical Liability Reform says “it’s time to play hardball” and “we will spend whatever it takes to keep this issue before the voters” (Jenkins 2004). Thomas Curry, executive director of the Washington State Medical Association, which represents 9,000 doctors, says they intend to target local legislative races. Curry says that “doctors in Washington state are prepared to spend hundreds of thousands of dollars this year to elect state lawmakers friendly to their cause” (Jenkins 2004). Activism by physicians at the state level is supported by the American Medical Association by such initiatives as the “AMA National House Call.” In August of 2004 AMA President, John Nelson, spent three days in Oregon meeting “with nearly 150 physicians and numerous print and broadcast journalists to bring the unified voice of the nation’s largest physician group behind an upcoming ballot measure that will help solve the crisis” (American Medical Association).

When Hillary Rodham Clinton went to speak at the American Medical Association’s annual meeting in 1993, the AMA official who introduced her “attempted to demonstrate the group’s authority and standing in American life when he said the AMA represents 90 percent of the doctors in the country and 100 percent of the patients” (Wolinsky and Brune 1994: 5). Although the “Voice of Medicine” claim might have fit somewhat in the 1960’s when approximately 75 percent of physicians in the United States were members, by the 1990’s the AMA, by its own data, had only “41 percent ‘market share’—its term for the proportion of eligible physicians who are members” (Wolinsky and Brune 1994: 5-6). Wolinsky and Brune argue that “a closer examination shows that the AMA exaggerates its membership figures to inflate its significance” (Wolinsky and Brune 1994: 6) just as HealthSouth exaggerated its earnings.<sup>670</sup>



Throughout their book Wolinsky and Brune argue that the American Medical Association is both more and less than it appears. The less includes the actual membership base and the veracity of the claim to represent “100 percent of the patients.” The more that allows the AMA to play larger than it is lies within its power as medical communicator through its medical journal (*Journal of the American Medical Association*), newspaper (*AMNews*), public relations apparatus (weekly news releases to about 4,000 medical and science journalists), standards-setting through the Joint Commission on Accreditation of Health Care Organizations (of which the AMA is a major owner), and through its political arm (American Medical Political Action Committee or AMPAC) (Wolinsky and Brune 1994: 2-11).

The AMA proudly cites *Fortune*, the *National Journal*, and *Roll Call* in supporting its claim of being “one of the most effective lobbying forces in Washington.”<sup>671</sup> Not coincidentally, the Center for Responsive Politics ranked the American Medical Association as number 10 among the “100 biggest givers in American politics since 1989.”<sup>672</sup> From 1989 to July 5, 2004, the American Medical Association contributed \$7,941,428 (38%) to the Democrats and \$12,304,268 (59%) to the Republicans for a total of \$20,734,136.<sup>673</sup> The break down by election cycle may be found in Table 8.1:

**Table 8.1 Center for Responsive Politics Data on Contributions by the American Medical Association by Total Amounts Per Election Cycle\***

Election Cycle	Total Amount (\$)	Democrats (%)	Republicans (%)
2004 (July 5)	1,066,816	27	73
2002	2,693,552	40	60
2000	2,283,402	47	53
1998	2,709,957	30	70
1996	2,865,656	24	76
1994	2,830,879	43	57
1992	3,444,655	49	51
1990	2,835,857	49	51

\*Source: Center for Responsive Politics, accessed August 25, 2004:  
<http://www.opensecrets.org/orgs/index.asp>

While a majority of physicians do not belong to the American Medical Association, it is still the case that this organization, which represents itself as the “Voice of Medicine,” wields considerable political influence.

### Political Correctness and Political Humor as Weapons of Market Medicine

There is a way of talking about health and health care systems that inhibits meaningful discourse and well serves those most invested in market medicine. One way of being a cooler for the market is exemplified by Sally Satel, a psychiatrist who is the W.H. Brady Fellow at the American Enterprise Institute. Satel charges that “the notion that social forces are major determinants of health” is “one of the most pernicious themes in PC medicine” (2000: 14). “Politically correct medicine” is Satel’s way of coding and delegitimizing “postmodern medicine” (2000: 11) and “a new academic enterprise called ‘the social production of disease’” (2000: 13) which, she argues, “puts ideology before patients” (2000: 6). “Indoctrinologists<sup>674</sup> have swooped under the radar” with dreams of social reform “to equalize the health status of all Americans by redistributing wealth,” which she argues is a prescription that “will be hazardous to our health” (Satel 2000: 7). While deconstructing *PC, M.D.: How Political Correctness is Corrupting Medicine* could easily be a dissertation in itself,<sup>675</sup> for this chapter it is sufficient to underscore two related points. The first is that ridicule is an effective tactic for dismissing data and analysis worthy of serious consideration. The second is to observe that critics of the status quo are characterized as ideologues and “indoctrinologists” while Satel’s own assumptions<sup>676</sup> are portrayed as neutral and value-free. Satel privileges discursive approaches to health (Exhibit 2.2) that are biomedical, individualistic, and purportedly apolitical in such a way that other discursive modalities are disappeared.

More skillful examples of political humor than Satel's ridicule may be illustrated by a number of physicians who use music and humor to animate discussion with their fellow physicians and other decision-makers on health care reform while simultaneously generating a profit. Dr. Sam<sup>677</sup> and the Managed Care Blues Band started to play at medical conventions "to make a political statement" with such songs as "You Picked a Fine Time to Leave Me Blue Shield," "You're One-Hipped Mama ('Cause They Won't Pay for Two)" and "Sorry Man But Your Bypass Is Considered Cosmetic" (Jackson 2001). In 1997 Iowa's Republican Rep. Greg Ganske, MD, ordered 535 copies of this CD and gave one to each senator and representative in Congress (Jackson 2001). Moving with the times, the new name of this band is now Dr. Sam and the Frivolous Action Blues Band and song titles such as "I Just Called To Say I Served You," "The First Time I Ever Sued Your Ass," and "Do You Know The Way to Hide Your Pay," on the latest CD reflect malpractice more than managed care themes, all for \$19.95.<sup>678</sup> Two internists, Barry Levy, and Greg LaGana,<sup>679</sup> wrote and sing "Damaged Care: The Musical Comedy About Health Care in America" in cabaret style.<sup>680</sup>

Perhaps the most influential satirist physician-activist is a family practice physician, Douglas Farrago, who produces the *Placebo Journal*,<sup>681</sup> the "Placebo Gazette,"<sup>682</sup> an upcoming book called *The Placebo Chronicles: Strange But True Tales From the Doctors' Lounge* (2005), and office accessories such as fake drug-ad posters.<sup>683</sup> On one hand, it is hard to dislike a publication with a tagline of "keeping our finger on the prostate of medicine" (Farrago 2004o). On the other hand, much of the humor is mean-spirited towards patients, especially those of the underclasses,<sup>684</sup> and self-serving in its support for market medicine. Farrago supports market medicine by such direct statements as "I love any advantage that goes to people paying real cash. To me that is the future" (Farrago 2004k) as well as by whimsical proclamations by the King of Medicine such as "thou shalt not whine about the bill; you spend more on your car"

(Farrago 2004e). Doug Farrago suggests that the number of uninsured in the United States is overstated (2004n; 2004o) and that “being without health insurance is not the same as being without health care” (2004n). Farrago slams universal health care by pointing at waiting lists in Canada,<sup>685</sup> he foments agitation on tort reform by advising physicians in Pennsylvania to “GET THE F&CK OUT!!!”,<sup>686</sup> and he advised a surgeon upset with Kentucky regulations on specialty hospitals to “opt out of Medicare and treat people who actually pay for your services themselves.”<sup>687</sup>

Political correctness is a label used by Farrago to sabotage thoughtful discourse as he accuses the Institute of Medicine of “getting in on the fad of being politically correct.”<sup>688</sup> Farrago celebrates “the courage” of those who have “the ‘cahones’ to be politically incorrect”<sup>689</sup> and a reader consoles Farrago by saying “Don’t let the P.C. Nazis get you down” (Farrago 2004d). The Placebo Gazette is a space where Farrago describes Chris Hawk as a “Placebo Gazette Hero” while opining “my feeling is this: unless you actually practice medicine...shut the f\*%k up” (Farrago 2004c). While defenders of the Placebo Gazette might argue that it is all merely in fun, one correspondent writes “yours continues to be the only honest publication in medicine” (Farrago 2004a) even as others default to house officer slang as they rant against “Medicaid grubbers” (Farrago 2004j) and Medicaid “dirt bags” (Farrago 2004i).

The Placebo Gazette’s “quote of the year” is attributed to Michael Gorback, MD and is telling:

We are so used to getting sodomized by insurance companies that we have stopped protesting about it. Now we just specify in our HMO contracts that they have to use a lubricant and we call it a victory (Farrago 2004h).

Sodomy is a pervasive metaphor in the echo-chamber that is the Placebo Gazette and it once again goes back to seeking congruence between self-regardingness of physicians and their pecuniary compensation:

A letter to the Placebo Gazette by “Dave H., MD” argues: “But let’s stop whining about all the problems with our soon-to-be bankrupt healthcare system and do something about it! Let’s start a political action committee to lobby government! We’ll call it P.L.A.C.E.B.O.PAC! (Physicians Losing All Control over being Economically Buttf@#cked Organization?) The goal is simple: get more money for doctors!” (Farrago 2004b).

Moving from this humor that is relentlessly political as it tries to depoliticize issues through attacks on political correctness, Chapter Nine will turn to organized medicine’s stance toward health care reform in Canada. Although the rhetoric is a bit more restrained on the surface, the use of sexual violence as a metaphor will also be visible in the Canadian Medical Association’s complaints against the Canada Health Act. The following chapter will explore other commonalities and differences in the ways that organized medicine in each country strategically represent and make real their preferred visions of how health care systems should be organized by considering tactics used in the Canadian context.

CHAPTER NINE  
"ZOMBIE-MASTERS"<sup>690</sup> FOR THE HEALTHY AND WEALTHY: ORGANIZED  
MEDICINE'S ROLE IN HEALTH CARE REFORM IN CANADA

Physicians' Discourses on Health Care Reform: Commonalities and Differences

"The NHS is over; we're all going to be rich. They have really pissed on their chips this time." My registrar is in a particularly bad mood: he has just seen the health minister on TV, accusing doctors of being greedy for not accepting the new consultants' contract... But when people start to be rude about us on telly, when we are made to look like the minority who practice badly, when patients are over-demanding and rude to us in casualty and in GP surgeries, then that's it. I'm telling you, with the mood every doctor in the country is in, this is the end of the NHS, the greatest state healthcare system in the world, which we were all truly proud to work in (Foxtton 2002).

This colorful passage by British physician, Michael Foxtton, permits a gathering together of discursive threads introduced in earlier chapters that are frequently reiterated by physicians within health care reform debates in industrialized nations. The first strand is nostalgia for a golden age of medicine that fostered a superlative health care system implicitly (or explicitly) tied with national identity. This golden age may be contrasted with the second strand, the current crisis, which heralds "the end" of whatever debacle posing as a health care system is under discussion. A third strand outlines physicians' hardships discussed in Chapter Seven: "working 33 hours in a row makes you feel shit: it makes you split up with your girlfriend, it loses you your mates, it stops your going out and it makes you crap at your job" (Foxtton 2002). The fourth strand calibrates assaults against the self-regardingness of physicians as justification to exit from a commitment to the common weal to a celebration of pecuniary rewards as consoling behavior. While the specific details may vary from context to context, these common and intertwined discursive themes are underpinned by the previously discussed structural dynamics of the infinite demand for health clashing with human mortality, finite resources, and loss of alternative, non-biomedical ways of making meaning out of pain, suffering, and death.

Looking at selected aspects of the Canadian health care reform experience allows one to see commonalities and differences. While many of the similarities in the structural claims made by physicians in the United States and Canada will be clear from the previous chapters, differences emerge in Canada out of a society that has a relatively small population spread over a large geographical area, more affinity for communal action that includes government,<sup>691</sup> and a lesser overall commitment to a reductionist politics of individualism. The entrenched economic rights in the United States Constitution of “life, liberty, and the pursuit of happiness” have often been contrasted with the corresponding fundamental constitutional principle in Canada of the preservation of “peace, order, and good government” (Evans 1988: 175).<sup>692</sup> The following sections will discuss how the structural claims of physicians may be similar in the United States and Canada but the content of the discourse changes because of fundamental differences in the logic of each system as well as the referential affinities of each audience.

### Physicians and the Structural Logic of the Canadian Health Care System

In contrast to the emotionally charged “socialized medicine” discussed in Chapter Three, the Canadian system of health care has been more properly described as “socialized insurance” (Evans 1988: 170). Provinces and territories administer universal health care insurance coverage by purchasing medical services from hospitals and private physicians in a “single-payer” system funded by federal and provincial/territorial taxes.<sup>693</sup> Having the provincial/territorial governments as exclusive suppliers of health care insurance, often identified in the literature as a kind of

monopsony, is “central to the control of health care expenditures, and through them to the management of health care delivery” (Evans 1988: 170).

Carolyn Hughes Tuohy suggests that at the initiation of this monopsony framework in the 1960’s, decisions about the allocation of resources were made through negotiations with the monopoly service providers, especially physicians. The “logic of accommodation between the medical profession and the state” is actually the “logic of an agency relationship in bilateral monopoly” (Tuohy 1999: 119).<sup>694</sup> Medicare was established “on generous terms” by underwriting the costs of an existing system of fee-for-service medical practice (Tuohy 1999: 119) and subsequent collective bargaining continues to be done by physicians’ associations on behalf of their memberships.<sup>695</sup> This bilateral monopoly of “provincial-level accommodations between the medical profession and the state” has served physicians well by affording them “a high degree of individual and collective autonomy” and it has served the state well by allowing governments to take credit for “a highly popular system” while exercising broad budgetary control (Tuohy 1999: 130). This autonomy arising from a functional bargain of professional/state collaboration in Canada may be contrasted with decreased autonomy experienced by physicians in a managed care environment in the United States. Physicians in the United States have higher incomes<sup>696</sup> but Canadian physicians have retained more of their clinical and economic<sup>697</sup> autonomy as well as collective policy-making influence (McCrea-Logie 2001: 1).

Congruent with resistance to the Saskatchewan Medical Care Insurance Act of 1961 that triggered the Saskatchewan doctors’ strike outlined in Chapter Three, organized medicine in Canada has had a consistently adversarial relationship with the principles of the Canada Health Act of 1984. Concerns about access to care occurred in the late 1970’s when some hospitals and physicians were billing patients directly for charges that were in addition to those already being paid by the government. This



prompted passage of the Canada Health Care Act, which is comprised of five principles: comprehensiveness (provinces have to cover “all medically necessary” services), accessibility (provinces have to ensure services are “reasonably” accessible and provided on “uniform terms and conditions”), universality of coverage (cover all citizens), public administration (provinces have to administer the plan directly or through a non-profit public agency), and portability (benefits have to be portable from province to province) (Rachlis and Kushner 1994: 35). The Canada Health Act specified that the federal government could withhold some of its financial contributions to the provinces<sup>698</sup> if any of the five basic tenets of the act were breached (Rachlis and Kushner 1994: 35). Widely supported by the public and passed unanimously by the House of Commons, the Canada Health Act was described as “constitutional rape” by the president of the Canadian Medical Association (Barlow 2002: 31).

Resistance to the Canada Health Act by physicians was perhaps most dramatically illustrated by the Ontario physicians’ strike of 1986. From the passage of the Canada Health Act on April 17, 1984 to the passage of Bill 94 in Ontario on June 20, 1986, which prohibited extra-billing by physicians, the federal government withheld more than \$100 million in federal support from the province of Ontario<sup>699</sup> (Meslin 1987). The Ontario Medical Association predictably argued that Bill 94, which curtailed what they preferred to term “balanced billing,” deprived “physicians of the right to contract directly for services” and would undermine the physician-patient relationship (Meslin 1987: 12). Bill 94 triggered a 23-day strike by 40% to 50% of the Ontario Medical Association’s 17,000 members.<sup>700</sup> Opposition to the Canada Health Act by physicians was consistent with “an ideological defense of professional dominance and autonomy” which serves as “expressions of the economic interests of physicians” (Stevenson, Williams, and Vayda 1988: 96).<sup>701</sup> This was further confirmed in 1992 when the board of the British Columbia Medical Association passed a resolution calling for an end of

Medicare using the rationale that it was unaffordable and “denied citizens the right...to purchase services in a free-competitive market” (Rachlis and Kushner 1994: 339).

It is therefore perhaps not surprising that organized medicine was conspicuously absent when health advocacy groups<sup>702</sup> and unions,<sup>703</sup> including nurses’ unions, filed an application in May 2003 in the Federal Court of Canada seeking a judicial review of the Minister of Health’s failures to monitor and enforce the Canada Health Act.<sup>704</sup> In fact, as shall be discussed within this chapter, some physicians and physicians’ groups have been among the most vociferous supporters of privatization<sup>705</sup> and the growth of for-profit health care in Canada, which the Canada Health Act originally sought to curtail.

One way to describe the health care system in Canada is to account for crisis in term of the principles of neoliberalism as the underlying ideology of globalization as described in Chapter Four. Although trade liberalization, deregulation, privatization, and the devolving state were features of the Brian Mulroney/Ronald Reagan/Margaret Thatcher regimes in the 1980’s, we can pick up this narrative with Finance Minister (and now Prime Minister) Paul Martin, “a humane and reluctant budget cutter” whose “goal in trashing social programs was ultimately to save them” (McQuaig 1998: 20). When Martin first became Finance Minister, “he felt that markets were holding a gun to his head” (McQuaig 1998: 99).<sup>706</sup> The federal budget that Martin brought down in February 1995 dramatically cut just about every federal program and slashed transfer payments to the provinces. By the time all the cuts were phased in during 1998-1999, federal spending on government programs would hit its lowest levels in fifty years, which was an era in comparison without Medicare or public pensions or unemployment insurance (McQuaig 1998: 98). The federal budget first balanced in 1997-1998 and then recorded six years of fiscal surpluses (Canadian Center for Policy Alternatives 2003b: 4). Fully 90 percent of the newly-available resources since the deficit was eliminated have been dedicated to tax cuts and debt repayment and only 10 percent to spending initiatives

(Canadian Center for Policy Alternatives 2003b: 1). Generating new revenue for social programs is difficult due to an ideological commitment to a devolving state: “by making deep and permanent tax cuts its top priority in the post-deficit fiscal environment, the government has tied its own hands” (Canadian Center for Policy Alternatives 2003b: 4). Between 1992 and 1996, public spending on health care fell by  $-0.5\%$  per year, public spending then increased by an annual rate of  $5.3\%$  between 1997 and 2001, followed by  $3.9\%$  in 2002, and  $4.3\%$  in 2003 (Canadian Center for Policy Alternatives 2004: 58). The important point to underscore here is that these trends reflect a political choice and not an economic necessity.<sup>707</sup>

As a result of this fiscal restructuring, the federal government’s share went from a historical high of almost  $50\%$  of health care costs (through a mix of tax points and cash support) to an estimated  $16.1\%$  in 2003-2004 as a share of health care costs to the provinces (Canadian Center for Policy Alternatives 2004: 58).<sup>708</sup> “Fundamental disagreements” between provincial, territorial, and federal governments about the adequacy of federal transfer payments has resulted in a deteriorating “federal-provincial political partnership” since the early 1980’s and an increasingly acrimonious environment<sup>709</sup> with “too little interactive decision-making on the issues that really matter” (Lazar et al. 2002: 5). Reduced financial resources for the provinces to spend on health care have been exacerbated by provincial tax cuts—“this year alone, the provinces gave away about \$20 billion through tax cuts” (Canadian Center for Policy Alternatives 2003a: 3). The actual amount that any health care system “needs” to deliver effective, efficient, quality care with universal access is open to interpretation. For the purposes of this chapter, the fundamental argument is that once deliberate policy decisions were made to privilege tax cuts and deficit reduction over maintaining a health care system that functioned not perfectly, but quite well, then the ensuing “crisis” caused by under-funding created the conditions of possibility for further neoliberal reforms such as

deregulation, privatization, public-private partnerships, and for-profit health services (trade liberalization). Once quality and access to health services are compromised, then those advocating “health care reform” as code for for-profit health care are situated to argue that publicly funded health care is inherently “unsustainable.”<sup>710</sup> Even after financial resources are at least partially restored, as promised by the 2004 Health Accord<sup>711</sup> to spend an extra \$41 billion over 10 years on health (Laghi and Tuck 2004), the Pandora’s box of neoliberal health care system reforms deliberately remains ajar as the following sections will illustrate.

#### A Quick Review of Market Medicine: Less Equity, Worse Quality, More Cost

As suggested in Chapter Six, a publicly financed, not-for-profit health insurance system in Canada has provided universal access at a lower cost (as measured in per capita spending on health and as percentage of gross domestic product spent on health) with better mortality outcomes (indicated by lower infant mortality and longer life expectancy) than the heterogeneous market-based system in the United States. While health disparities, especially among Canada’s First Nations peoples, and waiting lists suggestive of curtailed access to medical services and technology indicate that Canada still has much to improve in terms of the social determinants of health and health services delivery, there are many sound reasons why Medicare has long been a cherished social program. “Medicare has consistently delivered affordable, timely, accessible and high quality care to the overwhelming majority of Canadians on the basis of need, not income” (Romanow 2002: xvi).

Following the logic of market fundamentalism discussed in earlier chapters, for-profit health care organizations and systems do behave differently than those organized around other rationales. For-profit enterprises “adopt whatever behaviours will maximize the margins of revenue over cost” (Evans et al. 2000: 16). As a former manager

of a number of Columbia/HCA hospitals pointed out, “Columbia hospitals exist to make money—period”<sup>712</sup> (Evans et al. 2000: 19). Sometimes, as shown in Chapter Eight with HealthSouth, HCA, and Tenet, these behaviors involve gaming the system. Evans and his colleagues point out that the fact that the largest healthcare industry leaders are engaged in such fraudulent behaviors indicates patterns that are systemic. “This behaviour is a natural outgrowth of the drive for profit” and a system built on this logic requires “careful, continuous, and costly, monitoring (Evans et al. 2000: 19).

What difference does a profit motive or an expectation by investors of 10%-15% return on investment<sup>713</sup> make on quality of health care provided? A meta-analysis of fifteen<sup>714</sup> observation studies, involving more than 26,000 hospitals and 38 million patients in the United States, found a higher risk of death for private for-profit hospitals compared with private not-for-profit hospitals (Devereaux, Shunemann et al. 2002). A meta-analysis comparing mortality rates in private for-profit and private non-for-profit hemodialysis centers in the United States also found an increased relative risk of death for private for-profit dialysis facilities, which was equivalent to 2,500 (with a possible range of 1,200 to 4,000) annual excessive deaths (Devereaux, Choi et al. 2002: 2449).<sup>715</sup> Investor-owned hospices provide less care to the dying than not-for-profit facilities and investor-owned nursing homes provide less nursing care and are more frequently cited for quality deficiencies (Woolhandler and Himmelstein 2004: 1814).

Worse mortality and quality of care outcomes in for-profit systems did not make the care provided any less expensive. Results from yet another meta-analysis demonstrated that private for-profit hospitals result in higher payment care than private not-for-profit hospitals in the United States (Devereaux et al. 2004: 1817).<sup>716</sup> Extrapolating from their findings of a 19% relative increase in payments for for-profit hospital care, if Canada were to convert half of the hospitals in the nation to private for-profit institutions, an extra \$3.6 billion would be needed annually (Devereaux et al. 2004:

1823). Moving from the institutional to the system level, the cost of administering health care<sup>717</sup> in the United States accounted for 31% of health care expenditures in the United States compared with 16.7% in Canada in 1999 (Woolhandler, Campbell, and Himmelstein 2003).

Given this preponderance of evidence, embracing market fundamentalism and advocating market medicine in the Canadian context is an invitation to resurrect zombies.

### Physicians as Zombie-Masters: Conflating Self-Interest and Public Interest

Like zombies in the night, these ideas may be intellectually dead but are never buried. They may lie dormant for a time—in the late sixties, for example, or the late eighties—but when stresses build up either in the health care system or in the wider public economy, they rise up and stalk the land (Evans et al. 1993: 3).

The specific zombies that Robert Evans and his colleagues are warning against in the above passage are user fees. Other zombie ideas are models of private markets and private financing that were presented to and rejected by the Royal Commission on Health Services in the 1960's that have resurfaced as medical savings accounts in the 1990's (Evans 1999: 28). "Zombie-masters" are those organizations and people who consistently revive and promote user charges as a public good even though they are motivated by the "expectation that they, or the people they represent, would benefit" (Evans et al. 1993: 4).

As mentioned in Chapter Six, Robert Evans simply, but importantly, points out "bluntly, in economic terms alone, what is good for some is bad for others" (1999: 28). Market-based health care reforms are underpinned by a "redistributive agenda" that is more costly for health care systems as a whole and, due to their regressive funding logic, these reforms tend to privilege those who are wealthy and healthy (Evans 1998).<sup>718</sup> "Any

shift from public to private financing, by whatever means, will necessarily transfer costs from those with higher to those with lower incomes, and from the healthy to the ill” (Evans 2002: iv).<sup>719</sup> Those advocating market reforms, however, tend not to use redistribution as a rationale but instead strategically link financial liability with use of care for “a more efficient and more effective health-care system” (Evans 2002: 38).<sup>720</sup> Some physicians and physicians’ groups might be tempted to be zombie-masters for market-based reforms both for entrepreneurial opportunities that would increase their revenue streams<sup>721</sup> and as those with higher incomes who could potentially benefit from more regressive taxation.<sup>722</sup>

Physicians in Canada, not unlike their medical colleagues in other contexts, have stated, as in the 1934 report of the Canadian Medical Association’s Committee on Economics that “doctors naturally should try to shape health policy to their specifications: ‘This is not a selfish motive because what is best for the medical profession must be best for the public’” (Naylor 1986: 256). A perhaps unintended consequence of privileging professional independence in the “bilateral monopoly” when Medicare was first established “was the extent to which organized medicine interpreted that independence as depending upon, and therefore conferring, special authority over the whole field of medicine” (Evans 1988: 170-171). Unsurprisingly then, this capacity to believe in their special authority has reinforced a conflating of the interests of physicians and those of their patients and the public over the decades:

Speaking to a gathering of Alberta doctors in the autumn of 1979, for instance, a high-ranking official of the CMA remarked: “Paying the doctor directly the way you would pay any professional for services clarifies the doctor-patient role. Patients are happier this way. It is not a matter of money.” The logical extension of this viewpoint was voiced by a practitioner representing thirty-five Toronto-area psychiatrists during public hearings on Ontario’s controversial Bill 94: “Discussion of fees is often an extremely useful, an extremely meaningful process within therapy itself” (Naylor 1986: 256).

These examples provided by David Naylor also perfectly illustrate Mary Ann Elston's definitions of political autonomy as "the right of the medical profession to make policy decisions as the legitimate experts on health matters," economic autonomy as "the right of doctors to determine their remuneration," and clinical or technical autonomy as "the right of the medical profession to set its standards and control clinical performance" (1991: 61). This nexus of "rights" framed as autonomy is consistent with and extends Paul Starr's cultural, social, and professional authority of medicine as a "sovereign profession."

Without dismissing the reality of genuine concerns and legitimate complaints that physicians may have about the Canadian health care system and their situated experience within in, the following discussion will focus on four ways that Canadian physicians have acted politically as zombie masters for market medicine. These four themes—labor action, entrepreneurial activities, lobbying/public relations, and legal challenges—are not exhaustive of all possible illustrations. They are, however, selected for their reiterative characteristics as tactics reminiscent of historical examples in Chapter Three and familiar from topical issues discussed in Chapter Eight.

#### Zombie-Masters at Work: Collective Action for Extra-Billing

Extra-billing was a part of a plan to "play hardball" advocated by the British Columbia Medical Association's president-elect, Alex Mandeville, in the spring of 1980. The negotiation threat was if the provincial government did not give the physicians a 30% fee hike, the doctors would "balance-bill" patients 40% (Farough 1996: 150). Going back to the earlier themes of self-regardingness and economic autonomy, a sentiment expressed in the *British Columbia Medical Journal* was "if the government doesn't recognize the value of doctors' services, the consumer must assume at least partial responsibility" (Farough 1996: 152). The British Columbia Medical Association



(BCMA)<sup>723</sup> did win “the largest fee increase by a medical association in Canada” just in time for the recession of 1982 but they lost the right to extra-bill by the passage of Bill 16 (Farough 1996: 158-159). Bill 16 provoked the following rhetoric from BCMA president, Dr. Ramond March, in August 1981 and a lawsuit against the province, which BCMA lost.<sup>724</sup>

Bill 16 means that the physicians of British Columbia have been stripped naked at the negotiating table, completely subservient to the government’s position. Bill 16 and its passage is against all the basic concepts of professionalism, of a free, open and just society unparalleled in Canadian medicine. The results can only lead to continuing bitterness, frustration, confrontation with government and withdrawal of services. It leaves you as a civil servant without any of their privileges and benefits (Farough 1996: 158).

Physicians in British Columbia have been characterized as “leading Canada’s 55,000 practising physicians down the path to militancy” with their “fund us or free us” position on the issue of public health care (Sibbald 1998: 1506). Strikes by doctors in British Columbia have been euphemized as “reduced-activity days” or RADs: in March of 1998, for example, approximately 97% of the province’s 6,500 nonsalaried physicians participated in 3 RADs (Sibbald 1998: 1506). Physicians in British Columbia have argued that “clawbacks” or declining fees “combined with a 7% population growth during the last 3 years, means that BC physicians work free of charge for 5 weeks each year—an annual donation of \$75 million” while the provincial government argues that the doctors “do 30% too much work” (Sibbald 1998: 1507). As noted during earlier historical periods in Canada or during disputes about managed care in the United States,<sup>725</sup> a feature of negotiations with northern and rural physicians in British Columbia was the extent to which “it’s not a question of more money” was combined with very specific demands for more money.<sup>726</sup>

Strikes, whether called “job actions,” “study days,” “withdrawal of services,” “reduced-activity days,” “work stoppages,” or “getting in the governments’ face”

(Sibbald 1998: 1505) have been described as “the norm” in the *Canadian Medical Association Journal* (Sibbald 1998: 1505) and expected as “part of the negotiating process between doctors and governments” in the Canadian mass media (O'Malley and Wood). A predictable part of this routine is strategic maneuvering by all parties to hold the rhetorical high ground.

Physicians' representatives have characterized “legal job actions” as “ethical and often improve health care for patients” (Baer 1997: 1268). The executive director of the Manitoba Medical Association, a lawyer named John Laplume, argued that strikes are in the long-term interests of patients:

If a physician burns out, how is that going to help continuity of care? Or if he doesn't burn out, but continues to absorb more and more mistreatment, the physician's attitude and disposition toward his work would suffer, and then patient care would suffer. It's not fair for patients to have to receive their care from demoralized, angry physicians (Baer 1997: 1269).

Ontario Medical Association board member, Dr. Diamond Allidina said “service withdrawal is not a matter of morality because it boils down to a straightforward contractual dispute between doctors and paymaster” (Baer 1997: 1269).<sup>727</sup> In contrast, Robert McMurtry, dean of medicine at the University of Western Ontario and orthopedic surgeon argued for Medicare reforms without physicians' strikes as he considers medicine a “moral enterprise” (Baer 1997: 1269).

The ever-tactful<sup>728</sup> provincial premier of Alberta, Ralph Klein reinforced a perception of physicians as “greedy”<sup>729</sup> even as he naturalized this desire for pecuniary reward, which underpins his vision of a multi-tiered health care system:

“Do you think (doctors) are there not to make money?” Klein said in reference to a profit motive that is part and parcel of the health-care system. “How do you think doctors buy their big houses? All doctors are in it for profits, that's why they go to school for many, many years, so their earning power can increase” (Olsen 2002).

While Klein's comments may, in an odd way, have been meant to justify profit as an understandable motivation due to their "many, many years" of study, the reaction by physicians was as outraged as the "pissed on their chips" complaint that opens this chapter.<sup>730</sup>

Meanwhile, Professor Arthur Schafer, director of the University of Manitoba's Center for Professional and Applied Ethics, describes strikes by physicians as reflective of a profession experiencing a difficult transition from the "model of professionalism to a more entrepreneurial model" (Baer 1997: 1270-1271). Schafer makes an explicit link between the "starvation wages and slave-labour conditions," that were described in Chapter Seven of this dissertation, to "an unrealistic and inflated sense of entitlement when they enter practice" (Baer 1997: 1271):

The inhumane training process interferes with young physicians' chances of developing normal personal and professional lives. In turn, the resulting "delayed gratification" drives young doctors into the billing mill the moment the opportunity arises. "That's almost a guarantee for a lot of dissatisfaction," Schaefer points out. "A lot of people feel doctors are greedy and self-serving, and a lot of doctors are feeling oppressed and hard done by" (Baer 1997: 1271).

A danger for physicians is that a legacy of withdrawing services for reasons that are perceived to be self-serving may compromise professional credibility,<sup>731</sup> as arguably was the case with the physicians' strikes that occurred in Saskatchewan in 1962 and in Ontario in 1986.

### Zombie-Master Entrepreneurial Activities

Some physicians in Canada are zombie-masters for market medicine through their activities in much the same way as some entrepreneurial physicians in the United States are coolers for the market as they propagate enhancement technologies, boutique practices<sup>732</sup> and specialty hospitals. In fact, the logic of market medicine for enhancement technologies that fall outside "medically necessary" publicly or privately insured health

services such as cosmetic surgery, eye surgery for visual acuity, and gender reassignment surgery<sup>733</sup> is essentially the same in both countries. While generating demand for medical services classified as discretionary, quality-of-life consumer purchases may follow the norms of the marketplace, engaging in entrepreneurial activities that may contravene the Canada Health Act requires some ideological commitment and rhetorical deftness in the Canadian context.

A significant illustration of a complicated<sup>734</sup> nexus of competing and contested interests and values may be found in the province of Alberta.<sup>735</sup> The Health Resources Group (HRG) opened a \$6 million,<sup>736</sup> 37-bed for-profit hospital in Calgary in September 1997 by taking over the third floor of the former Grace Hospital, which had recently been closed by the provincial government. The business environment for the Health Resources Group was greatly improved by the closure of three acute care hospitals, the loss of more than 1,500 hospital jobs from 1993 to 1997, and a 20% reduction in the province's health care budget which provided demand for services, a labor force that was preferably non-union,<sup>737</sup> and regional health officials willing to "look at the potential for private-private partnerships with for-profit providers" (Fuller 1998: 183-184). The Health Resources Group was formed by "a group of investors,<sup>738</sup> former regional health officials,<sup>739</sup> and physicians"<sup>740</sup> (Fuller 1998: 183) who, not incidentally, had "strong ties with the province's ruling Conservative party"<sup>741</sup> (Fuller 1998: 184).

After the public health care system was deliberately underfunded, the chief executive officer of Health Resources Group, Jim Saunders explained that "HRG wants to serve as a private facility that 'enhances' the overburdened public system" by shortening waiting lists for some procedures "the public system has trouble providing" (Cairney 1998: 552). Dr. Stephen Miller, chief medical officer of HRG, defended complaints that "the for-profit hospital spelled the end of medicare in Alberta," by arguing "the facility would not take away anything from the public system" (Fuller

1998: 187).<sup>742</sup> Once HRG was approved as a “non-hospital surgical facility”<sup>743</sup> allowing patients to stay overnight at the end of 2001, Miller lauded HRG as a “creative way” for physicians “to be able to give more and better care to their patients” in a health care system “that has limited resources”<sup>744</sup> (Kermode-Scott 2002). From the perspective of some health economists, private clinics are a kind of extra-billing under a new name that provide “motivation and opportunity to promote additional, uninsured services, which carry substantial profit margins” (Evans et al. 2000: 23).<sup>745</sup>

Alberta, as “Canada’s Petri Dish of privatization” (Barlow 2002: 122), is worth attending to, especially as “a defiant Premier Ralph Klein reiterated his vow to introduce radical health care reforms if voters give him a renewed mandate in an election”<sup>746</sup> expected in the fall of 2004 (Gregoire 2004: 226). These “radical reforms” include the possibility of opting out of the Canada Health Act altogether (Maccharles 2004). For the purposes of this chapter, it is important to note the significant role that physicians played in giving their cultural, social, and professional authority to legitimate Health Resources Group’s actualization. The Health Resources Group, like the specialty hospitals discussed in Chapter Eight, portrays cherry-picking as efficient, quality care that will improve access even as the mantra of “it isn’t about profit” is duly repeated by those in leadership positions<sup>747</sup> (Cairney 2000b: 409). The Health Resources Group is also significant for precipitating Alberta’s Bill 11, disingenuously named the Health Care Protection Act, which was passed in 2000. This legislation not only allows for-profit hospitals to provide surgical services covered under the provincial health plan but it also allows physicians to practice in both the public and for-profit systems (Barlow 2002: 126).<sup>748</sup> A difficulty with physicians practicing in both systems is that waiting lists are increased and not decreased, as frequently claimed. In Manitoba in 1998-1999, for example, the average wait time for cataract surgery for physicians who operate only in the public system was ten weeks while the average wait time was over twenty-six weeks

for physicians operating in both the public and for-profit systems (Sullivan and Baranek 2002: 63).

Amidst the swirl of health care reform commissions such as the National Forum on Health (1997) and the Commission on the Future of Health Care in Canada, which tended to support the essential elements of the Canada Health Act, and the Premier's Advisory Council on Health for Alberta (Mazankowski 2001) and the Standing Senate Committee on Social Affairs, Science and Technology<sup>749</sup> (Kirby 2002), which advocated more market-based health care reforms, certain provinces have been moving ahead with privatization without serious opposition by the federal government.<sup>750</sup> The Commission on the Future of Health Care in Canada makes a distinction between ancillary<sup>751</sup> and direct health care services<sup>752</sup> and argues that the latter should be delivered in public, not-for-profit facilities (Romanow 2002: 7). Privatization initiatives have included shifting formerly publicly funded services to the private realm by delisting services or adding user fees, out-sourcing ancillary services, and commercializing health care through "public-private partnerships" (often called P3s), allowing direct health care services to be provided by the for-profit sector (such as Health Resources Group), and for-profit diagnostic facilities.<sup>753</sup>

The big picture is that Alberta, British Columbia, and Ontario, Canada's richest provinces, have been the ones who have "engaged in the most pessimistic rhetoric about the sustainability of medicare" (Lewis 2004: 601) and have engaged in the most aggressive pursuit of privatization (Barlow 2002: 131). A structure of for-profit health care along with increasing out-of-pocket expenses by delisting services that were previously publicly insured provides revenue-generating opportunities not only for corporations and health care providers but also as a market for private insurance. "Private medicine and private insurance are symbiotic"<sup>754</sup> (Evans 1999: 38). While private insurance adds costs to the system and may not be available to the unhealthy

and unwealthy<sup>755</sup> as discussed earlier in this dissertation, it is income for a powerful group of corporate interests. A movement from universal health insurance to private health insurance in Canada could promote a downward spiral as “people who rely primarily on private insurance become a constituency not for improvements but for further deterioration—if you do not use it why pay taxes for it? (Evans 1999: 39)

The mildest way to tell this story is that provinces are experimenting with privatization in the context of an ambivalent federal government that wants political capital for both fiscal responsibility and for a popular social program. A sharper critique views provincial and municipal privatization initiatives as part of the structural adjustment of Canada going back ideologically to Reagan/Thatcher/Mulroney and most dramatically operationalized by Paul Martin’s budget of 1995.<sup>756</sup> Whether accidental or deliberate, there are glaring ways in which the objectives of one federal department will work at cross-purposes with that of another federal department. What are perceived as expenditures for medical services in one part of the government are perceived as entrepreneurial opportunities in another federal department. Within Industry Canada, for example, there is the Public-Private Partnership (P3) Office, a “center of knowledge and expertise on P3 issues” as “P3s offer promising new business opportunities for Canadian service firms” (Grieshaber-Otto and Sinclair 2004: 122).

Prime Minister Paul Martin appointed MP John McKay as his parliamentary secretary responsible for public-private partnerships. In an interview with the *National Post*, McKay explained that although plans are not final, there is a “a lot of noodling going on at pretty significant levels in the civil service and among public policy wonks who have all kind of unanimously come to the conclusion that we can’t carry on the way we’re carrying on” (sic) (Curry 2004). McKay reinforces this inevitable need for change by saying “the whole system needs to be brought into the 21<sup>st</sup> century. If we were in

private business we'd be out of business" (Curry 2004). The stakes are raised even higher as McKay warns:

Because the choice is not between same old, same old government doing things the way they've been doing it and P3s. The choice is P3 or nothing and Canadians are going to have to face the issue: Why does a public entity have to own the hospital? Why does a public entity have to finance a hospital? (Curry 2004)

While McKay's perspective might be helpful for generating entrepreneurial activity, an inability to differentiate the role of government from that of business or public goods from private goods or compelling reasons why a public entity should finance a hospital<sup>757</sup> does not well serve Health Canada's objectives targeted toward improving health and health care services. This fragmented approach at the level of political leadership has been found especially prevalent among federal and provincial civil servants in finance departments, who tended not to believe that health was relevant to what they did or that health determinants should be considered when assessing all major government initiatives<sup>758</sup> (Lavis et al. 2003: 662). Different government departments and actors serve different constituents and agendas with different policies or non-policies that privilege some interests and people over others.

Globalization is important to the politics of health care reform in this chapter in a number of significant ways. The ideology of neoliberalism provides the philosophical and programmatic underpinning for Canada's structural adjustment that favors debt reduction and tax cuts over social spending. A growing culture of market fundamentalism legitimates and provides increasing opportunities for entrepreneurial activity by physicians just as those policies generate increased demand for medical services by increasing poverty, hunger, homelessness, and income inequality as discussed in Chapter Four. Trade liberalization, privatization, deregulation, and a shrinking welfare state as ideology and macroeconomic policy have real consequences for actual people.



The enforcement arm of market fundamentalism is international trade agreements. The North American Free Trade Agreement (NAFTA) “was always intended to make it difficult for governments to back away from economic liberalization” (Appleton 1999: 99). While there are deliberately no property rights protected in the Canadian Constitution, “NAFTA creates property rights for foreign investors in Canada” (Appleton 1999: 101).<sup>759</sup> While some aspects of NAFTA and the General Agreement on Trade in Services (GATS) are important to those who seek advantage in obtaining access to markets abroad, other aspects of NAFTA and GATS threaten Canada’s universal publicly funded health care system (Sanger 2001: ii). Under GATS’s Article 1.3, medical services in hospitals are protected as long as they are not in competition with private facilities and are provided on a non-commercial basis. The previously described Alberta Bill 11 undermines this GATS’s protection and Canada’s NAFTA obligations so that the Canadian health care system could be exposed “to a potentially ruinous trade challenge” (Sanger 2001: v). Increasing commercialization through for-profit delivery of services, private financing, and market-based models for allocating funds threatens “to set in motion a self-reinforcing dynamic—a vicious circle—that could undermine the foundations of Canada’s Medicare system” (Campbell et al. 2002: ix):

Commercialization weakens the protective effect of trade treaty safeguards for health at the same time that it facilitates the entry of foreign investors and service providers into newly created markets in health services. The greater the presence of foreign investors and service providers, the greater the possibility of trade disputes if governments take actions that limit or reverse foreign penetration. Thus, once foreign investors and service providers become involved in Canada’s health care system—and the more involved they become—the more difficult and costly it will be to limit or reverse the trend toward commercialization in general (Campbell et al. 2002: ix)

While more specific details are available,<sup>760</sup> the important point is that the market-based reforms being aggressively pursued in Alberta, British Columbia, and

Ontario have implications for the entire nation. Supporters of trade liberalization, including the government of Alberta,<sup>761</sup> have provided assurances that various trade agreements will not have an impact on health, but there is a preponderance of evidence suggesting that final outcomes of future trade disputes are, at best, uncertain<sup>762</sup> (Romanow 2002: 237).

### Zombie-Masters Foment Crisis: Lobbying and Public Relations

In addition to the slogan of “Leadership for Physicians...Health for Canadians” and the self-description as “the national voice of Canadian physicians” (Haddad 2001), another tag line of the Canadian Medical Association (CMA) is that “CMA is leading the debate on the future of health and health care in Canada” (Canadian Medical Association 2000). The CMA Charter for Physicians makes an argument that a “quality health care system” is linked not only to physicians’ participation in health care reform but in protection of how doctors are paid:

Canadian physicians have a vital role in the health care system and can provide essential expertise about health system organization, funding, and service delivery. In order to preserve and promote a quality health care system, Canadian physicians need: to be consulted and involved meaningfully in health system reform and policy planning, and on issues related to service delivery, payment, funding, and terms and conditions of work, and to be assured that changes to the health care system will respect individual medical practitioners’ liberty to choose among payment methods (Canadian Medical Association Board of Directors 1998: 4).<sup>763</sup>

The CMA Policy on Physician Compensation more explicitly interprets “a physician’s right to choose a payment method” or physicians’ “freedom to choose their method of remuneration” as democratic rights<sup>764</sup> (Canadian Medical Association 2001: 2). While both the CMA Charter for Physicians and the CMA Policy on Physician Compensation underscore the importance of collective bargaining and collective negotiation, it is not immediately obvious within their argumentation how payment method might be justified as a democratic right.

The Canadian Medical Association and its provincial counter-parts have historically been successful as political elites as a “force for entrenchment of the core bargains<sup>765</sup> (e.g. maintenance of private practice and fee-for-service remuneration in the *National Medical Act* of 1966) and as a force against proposed repeals of an element of the core bargains (e.g. primary care reform that involves a change in the physician remuneration method from fee-to-service to capitation)” (Lavis 2002: 8). Physicians and their associations are able to influence health care reform by their professional authority; “still viewed by many citizens as authoritative agents acting in their best interests,” doctors speak “one-on-one” with about 78% of Canadians each year (Lavis 2002: 12). According to John Lavis, health care reform may be influenced by use of physician’ political, social, and economic resources in three ways. The most obvious and less common is the use of strikes, which have been discussed previously. The next most visible tactic is to directly voice opposition to reform measures either directly or “behind closed doors.” The last tactic, which is the most difficult to study, is exerting influence “by engendering an anticipatory reaction on the part of provincial government officials” (Lavis 2002: 12).

Two federal studies, the Royal Commission on the Future of Health Care in Canada (Romanow 2002) and the Standing Senate Committee on Social Affairs, Science and Technology’s investigation into public health infrastructure (Kirby 2002), as well as several provincial commissions on health care reform (Clair 2001; Fyke 2001; Mazankowski 2001) provided the Canadian Medical Association as well as others multiple opportunities to testify about their preferred vision of the health care system. Although there are very real difficulties within the Canadian health care system that need to be addressed, a helpful way of understanding organized medicine’s strategic representation of health care reform is “orchestrated outrage” (Marmor and Sullivan 2000: 16). The Canadian Medical Association’s brief to the Royal Commission on the

Future of Health Care in Canada is called *Getting the Diagnosis Right: Toward a Sustainable Future for Canadian Health Care Policy*. The “signs and symptoms” of the “traumatized patient” that is the Canadian health care system are vividly portrayed in terms of 1) crisis of access—accessibility means nothing without availability; 2) crisis of provider morale; 3) crisis of public confidence; 4) crisis of health system financing (framed in terms of demographics and technology); and 5) crisis of accountability and cooperative mechanisms (Haddad 2001). While this report is careful to affirm that “Medicare is the last remaining universal program in Canada and needs to be preserved and protected” (Haddad 2001: 15), “pathways to stabilizing the traumatized patient” included a challenge to “generate new thinking” to promote flexibility, adaptability, “collaborative approaches,” and “meaningful involvement of all key stakeholders” (Haddad 2001: 14-19), which are often codes for market based reforms.

The threat of Medicare being “unsustainable” is strategically reiterated in the Canadian Medical Association’s discourse on health care reform. “We are deeply concerned that Canadians’ confidence in our system is hovering at a level that threatens the sustainability of the social consensus that underlies our current Medicare program” (Haddad 2001: 9). Evidence for this fraying of social consensus was provided by opinion polls funded by the Canadian Medical Association from 2001 to 2004; polling data making sustainability an issue over other possibilities is communicated with the title, *2004 National Report Card: On the Sustainability of the Health Care System* (Ipsos-Reid Corporation 2004). Questions linked to quality,<sup>766</sup> efficiency,<sup>767</sup> and access/cost framed as “sustainability”<sup>768</sup> were then used to argue that “Canadians gave the health system an overall grade of ‘C’ (Canadian Medical Association 2004b: 1). Shaping public perceptions and future possibilities by the content of the research questions, pollsters reported that 71% of the respondents “agreed that they would prefer faster access to essential services rather than slower access to a more comprehensive list of services”

(Ipsos-Reid Corporation 2004: 25) thereby legitimating delisting services. A public information "Factsheet" on sustainability normalizes privatization of medical services even further. It presents "have the right to buy private health care to obtain timely access" as a contested perspective on "public attitudes on health spending" rather than as their preferred vision of financing medical services<sup>769</sup>(Canadian Medical Association 2004a: 2).

One of two other forms of lobbying/public relations to be briefly mentioned is a paradigmatic communication in the form of "The President's Letter," which announced the Alberta Medical Association's motion that "calls upon the federal, provincial and territorial governments to respect the role and independence of physicians in their private delivery of publicly funded medical services" (Bunting 2004: 3). In this rhetoric "private" has become code for for-profit and physicians' outrage now is that "there are some in Canada who want to ban private delivery of publicly funded services even though it is perfectly legal<sup>770</sup> to do so and is allowed under the *Canada Health Act*" (Bunting 2004: 2). Reinterpreting the failure of the federal government to uphold the *Canada Health Act* is now strategically portrayed as "perfectly legal" professional behavior that should not be constrained.

While the Alberta Medical Association's communication appeals explicitly to norms of market fundamentalism intellectually using a rationale of legality, some appeals by organized medicine appeal directly to the emotions of the audience. A feature of public relations campaigns sponsored by physicians' associations that is unchanged from the 1949 "Keep Politics Out of This Picture" poster discussed in Chapter Three is the poignant portrayal of exhausted physicians, photogenic children, and distraught parents. Although the technology has changed so that visual media can easily be accessed on the Internet, the visual iconography still grabs at people's most primal fears for their loved ones and themselves. A crying mother holding a baby and a

montage of worried and exhausted physicians are the instrumental images used on the cover of the Canadian Medical Association's report *Better Access, Better Health: Accessible, Available and Sustainable Health Care for Patients* (2004b). The Ontario Medical Association's Public Information Series <sup>771</sup> includes newspaper ads that ask: "Concerned about long wait times for medical tests and treatment?" above a young girl with big eyes peeking out over an oxygen mask. While the appeal is emotional and depends on crisis-generation, the Ontario Medical Association's eighteen recommendations to alleviate physician shortages in the province include dry-eyed recommendations on malpractice reform and the elimination of "coercive billing."<sup>772</sup>

Discourses of organized medicine that use emotional imagery and rhetoric of crisis and exaggerated warnings about sustainability of the health care system feed public anxiety exacerbated by media accounts of patients flocking to the United States for care, physicians fleeing Canada for greener pastures, and calamitously declining quality of care. On the other hand, a compelling case has been made, respectively, that "the streams of wealthy Canadians" heading south for care unavailable in Canada<sup>773</sup> (Evans et al. 2000: 47), "the great Canadian physician exodus"<sup>774</sup> (Barer and Webber 2000), and different attributions within reports of emergency room crowding in during an influenza outbreak in the United States and Canada<sup>775</sup> (Marmor and Sullivan 2000) are all, in certain senses, media myths. As these demythologizers point out, tales of the flaming decline of Canadian Medicare serve powerful interests and ideologies on both sides of the border. Recent news coverage in the *New York Times*, for example, states that publicly financed health insurance is "a prideful jewel" for most Canadians "but polls indicate that public confidence in the system is eroding, although politicians remain reticent to urge increasing privatization of services" (Krauss 2004). This account uses evidence provided by organized medicine <sup>776</sup> and the more market-orientated Kirby report<sup>777</sup> to support a familiar conclusion:

“If the current trends continue we can anticipate a crisis,” warned Joseph D’Cruz, a University of Toronto business school professor who specializes in health care. “People will actually find it impossible to get general medical services in their towns” (Krauss 2004).

A perceived crisis of Canadian Medicare allows single-payer health insurance to be dismissed as a possibility in the United States and it creates the conditions for greater entrepreneurial opportunities in Canada. This trajectory towards profit, once again, was orchestrated by following the neoliberal tenets of trade liberalization, deregulation, privatization, and shrinking of the welfare state thereby eroding public services. Compromised services were then held up as proof that private solutions were needed in order to improve the quality of the system. For-profit medicine (with pressure for for-profit insurance lurking in the background) will further erode access for the unwealthy and unhealthy while the consequences of future litigation based on multinational trade agreements remains uncertain. The Canadian Medical Association, provincial medical associations, and influential marketized health system reform proponents such as Dr. David Glatzer<sup>778</sup> are all zombie-masters in that they use their professional authority to legitimate “living dead” ideas that would otherwise be staked-through-the-heart-and buried based on the evidence of their merits.

#### Zombie-Masters Approach the Bench: Legal Challenges to Medicare

The *Charter of Rights and Freedoms*, enacted in 1982, covers governments’ policies about health care. In twenty years there have been 33 *Charter* actions that have challenged health care policies, of these 11 were successful (Greschner 2002: v). While the *Charter* has implications for issues such as the right to refuse medical care<sup>779</sup> and a broad range of access issues such as the scope of insured services,<sup>780</sup> for the purposes of this section, discussion will be limited to specific instances where physicians have attempted to use the Charter to advance their claims.

In the 1980's and 1990's physicians used section 6 (mobility rights), and section 7 (life, liberty, and security of the person) to challenge provincial government policies on billing numbers, which sought to restrict new doctors to under-serviced areas in British Columbia. Physicians won three cases in British Columbia but more recently the Supreme Court and the New Brunswick Court of Appeals have rejected challenges to similar billing policies (Greschner 2002: 3). The simple point to note here is that possibilities for health system reform in terms of allocating human resources, control of costs, and new initiatives such as employment contracts or capitation might be subject to *Charter* challenges and adjudication<sup>781</sup> (Greschner 2002: 15).

On June 8, 2004 the Supreme Court of Canada heard a case that "could destroy the very basis of universal medicare" (Bueckert 2004a).<sup>782</sup> Montreal physician, Jacques Chaoulli<sup>783</sup> and his patient, George Zeliotis,<sup>784</sup> are asking the Supreme Court to overturn two earlier judgments<sup>785</sup> that upheld Québec laws limiting the use of private medical services and medical insurance (Sullivan 2004). Dr. Chaoulli told the court that "people are suffering and dying on waiting lists in the public system" but "doctors who have left the country could return to work in private hospitals and clinics" (Tibbetts 2004).

Testifying strongly in support of Chaoulli and Zeliotis was counsel for the British Columbia Anaesthesiologists Society, British Columbia Orthopaedic Association, and 14 for-profit clinics<sup>786</sup> from British Columbia who argued:

In essence, Canada has tried to turn our system of providing medical care into a State-controlled monopoly. We don't say that that's unprincipled, immoral or necessarily wrong even, but that's what they have tried to do and it might be a nice theory to try to do that, but if the theory isn't working, then something's got to give and we suggest, with respect, that this case will help with that giving (Chaoulli v. Quebec 2004: 59-60).

In the view of these interveners, "the Canadian approach is no more obviously egalitarian and yet it violates fundamental rights of personal autonomy and security to an extent which is unparalleled in any other developed country" (Chaoulli v. Quebec



2004: 64). The Canadian Medical Association and the Canadian Orthopaedic Association (CMA/COA) had a joint position that was similar to the intervener position of Senator Kirby and ten senators. The first line of the written factum stated that CMA/COA “support the existing single payer (public funded) model of health care delivery, but are concerned that delays to medically necessary health care may put the life and health of patients in Canada at risk” (2004: 1). The president of the Canadian Medical Association’s represented the position of his organization in the mass media<sup>787</sup> only as supportive of the existing system without acknowledging the qualifications so clearly expressed in CMA/COA court presentation (Patel 2004). The lawyer for the CMA/COA, Guy Pratte’s introductory oral statements fulsomely stated “the promise of universal accessibility to healthcare is meaningless unless it means timely access. Healthcare delayed is healthcare denied” (Chaoulli v. Quebec 2004: 51). The wedge for for-profit medicine and private insurance may be found in their statement “The only proportionate response would be to guarantee timely access within the system or if you can’t guarantee it within the system, allow the person and pay for the person’s services out of the system” (Chaoulli v. Quebec 2004: 56).

Written and oral testimony was presented by federal and provincial governments, and the Canadian Labour Congress. Speaking on behalf of the Charter Committee on Poverty Issues and the Canadian Health Coalition, Martha Jackman argued:

What the Appellants are in fact claiming in this case is not a right to choose private care which they already possess. Rather, the Appellants are confounding private care which is absolutely allowed in Canada and private funding which is not. The Appellants are arguing that section 7 of the *Charter* prevents Governments from legislating in a way that makes the provision and sale a private healthcare economically unattractive for profit providers operating in a public market. In other words, the Appellants are proposing that section 7 guarantees the right of private healthcare providers to sell private health insurance in the most favourable possible market conditions, that is, with direct and hidden subsidies from the public system (Chaoulli v. Quebec 2004: 118).

*Chaoulli v. Québec* is a microcosm of the main arguments presented in this chapter. Dr. Jacques Chaoulli strategically represents a health system crisis by privileging waiting lists as the rationale for dismantling Canada's system of social insurance so that he can pursue his "right" to engage in entrepreneurial activity. His co-appellant, George Zeliotis, as an older, unhealthy self-employed person is fighting for a "right" to purchase private insurance that he would probably be unable to access due to cost or his pre-existing medical conditions.<sup>788</sup> Collective labor action by physicians, in this example, is most dramatically represented by professional organizations and for-profit clinics who recklessly discount a plethora of evidence on quality, efficiency, and access in comparative health systems (available in earlier chapters of this dissertation) to argue for their own entrepreneurial interests which they frame as the public good. The Canadian Medical Association does the same thing but with greater attentiveness to public relations in that one has to comb through scads of testimony in two official languages to disprove the incompleteness of their public claims that their support for Medicare is unqualified. The organized groups fighting to preserve the tenets of the Canada Health Act are not mainstream organized medicine but coalitions of labor, citizen, and consumer groups.

*Chaoulli v. Québec* is zombie-masters running amuck. While not all<sup>789</sup> zombie-masters are physicians, in this specific illustration, all the physicians are zombie-masters. The last chapter will argue, in conclusion, that behaving as coolers and zombie-masters, although understandable in a culture of market fundamentalism as consoling mechanisms for self-regardingness, has adverse consequences for health systems, population health, and a vibrant community life.

## CHAPTER TEN PROFESSIONAL CAPITAL AND THE COMMON WEAL

Pete Sarsfield is a physician from a working class background who has worked extensively in First Nations' communities in Canada. Sarsfield recounts a conversation between a Dene man living in the Northwest Territories and an acquaintance:

They were talking about the rules of conduct observed by Dene travelers, a signpost discussion important to both of us. The Dene man was telling how a returning traveler had an obligation to tell someone else who was about to set out over the same terrain every detail of information he had observed, specifying land, water, animal, human, and weather variables along the route, omitting nothing. This sharing of knowledge is not merely a friendly gesture and is not optional, but is instead a necessary part of the social contract, a duty. The man I am talking to, as we walk over foreign Denendeh turf, asked the Dene man if any people ever choose to keep the information to themselves, for their own benefit. "Oh, you mean *professionals*," said the Dene man, shaking his head (1997:168).

Outside of a context of market fundamentalism,<sup>790</sup> the sharing of knowledge and expertise may be viewed as "a necessary part of the social contract, a duty." This is not a work of charity or a commodified service but a part of social relations that will be reciprocated when the giver of practical insight today is the one seeking guidance for the journey next month. This way of perceiving knowledge will be contrasted in this concluding chapter with the logic of accumulating educational<sup>791</sup> and professional capital for individual gain that is an ever-increasing hallmark of the politics of professional medical labor.

Bringing forward the various threads from the previous chapters, the essential argument of this dissertation is that the politics of health articulated and lived out by mainstream organized medicine has predictable consequences for health care systems and population health. While certainly not all, or even a majority of physicians in the United States and Canada, may individually belong to or totally agree with their professional associations, it remains that "as the voice of medicine" in their respective countries, the American Medical Association and the Canadian Medical Association use

their professional authority to articulate their preferred visions of health care reform. The habitual conflation by organized medicine of “what is good for physicians” as being identical with “what is good for patients” is not innocent. In addition to national professional bodies, state and provincial medical associations, and professional organizations affiliated by specialty or interest (such as malpractice reform), some individual entrepreneurial physicians also reinforce the culture and norms of marketized medicine.

Although Physicians for a National Health Program<sup>792</sup> have presented a compelling rationale for national health insurance (Himmelstein and Woolhandler 1989; Physicians' Working Group for Single-Payer National Health Insurance 2003), a common assessment is that this will not happen in God's lifetime<sup>793</sup> (Reinhardt 2003). In concert with other reasons for the abysmal prospects of improving access to health insurance in the United States, the predominately negative attitude of physicians towards public financing of health care exacerbates the status quo. One national survey<sup>794</sup> of physicians found only 26% supported a single-payer health care financing system (Ackermann and Carroll 2003).<sup>795</sup> Supporters of universal health insurance continue to be routinely mischaracterized as advocates of “socialized medicine” in both the biomedical literature and mass media while critical scholarship is often ignored or maligned as being ideological. Marxist interpretations of medicine and the political economy of health (Navarro 1976; Brown 1979; Waitzkin 1983) are marginalized by being dismissed simply for being Marxist without first precipitating a substantive engagement with a critique of capitalism.<sup>796</sup>

Despite the remarkable efforts of some clinicians, researchers, academics, and policy analysts who advocate as physicians for substantive health care reform,<sup>797</sup> the hegemonic discursive text of health care reform in the United States is that provided by the American Medical Association. The AMA's policy since 1998 and their most current

proposal for health care reform calls for increasing access to health insurance through tax credits, individually selected and owned health insurance, and expanding insurance markets (Palmisano, Emmons, and Wozniak 2004). “Consumer choice—choice of plan and choice of physicians and other health care professionals—is a cornerstone of the AMA proposal to expand coverage” as is an explicit aspiration to “limit the role of government” (Palmisano, Emmons, and Wozniak 2004: 2240). This vision is perfectly congruent with President George W. Bush’s public statements on health care reform:

The American system of medicine is a model of skill and innovation, with a pace of discovery that is adding good years to our lives. Yet for many people, medical care costs too much -- and many have no coverage at all. These problems will not be solved with a nationalized health care system that dictates coverage and rations care. Instead, we must work toward a system in which all Americans have a good insurance policy, choose their own doctors, and seniors and low-income Americans receive the help they need. Instead of bureaucrats and trial lawyers and HMOs, we must put doctors and nurses and patients back in charge of American medicine. President George W. Bush, January 28, 2003<sup>798</sup>

President Bush’s excerpt from the “State of the Union” address does a magnificent job of using the themes of efficiency, quality, and equity discussed in Chapter Six as operational terms of health care reform. Within a few short sentences Bush manages to both valorize the technical, market-based biomedical system that “is adding good years to our lives” while raising concerns about cost, quality, and equitable access that arise from the “bureaucrats and trial lawyers and HMOs” of the status quo as well as the specter of a nationalized health care system “that dictates coverage and rations care.” The goal of putting “doctors and nurses and patients back in charge of American medicine” is inexorably linked in this perspective to “a good insurance policy” and individual choice of physician. Bush’s appeals to cost, quality, and equity to support his preferred version of market-based health care reform hide the “redistributive agenda” (Evans 1998) characterized by regressive funding policies that make those in poor health and with low-income actually less likely to receive the

medical care they need. Promises of lower cost, higher quality, and more equitable health care services for all Americans through commodified medicine comprise a trinity of faith within market fundamentalism, a faith actively proselytized by the American Medical Association.<sup>799</sup>

The behavior and rhetoric of physicians and their organizations to valorize market medicine, legitimize neoliberalism, and celebrate consumerism as mechanisms of affirming their self-regardingness has important consequences and likely trajectories. An infinite demand for health is pushed by medicalization and evolving technologies that are ever expanding the warrant of medicine into new product lines such as enhancement technologies and pharmacogenomics. A population that is aging and patients who increasingly self-identify as “consumers” with expectations fueled by mass media and the Internet increase “natural” and induced demand. Physician status needs within this particular culture are soothed not only by pecuniary rewards that may be redeemed in a consumer society but also by affiliation with high prestige, high technology, usually urbanized research and practice patterns. These factors drive up costs for health care systems without corresponding guarantees about quality, efficiency, and access. While regulations may try to mitigate costs, encourage efficiency and quality, and expand access for those who have a claim on the system, the trajectory of an increasingly commodified health care system is a) completely class-based health care and/or b) collapse of the system. A completely bifurcated health care system based on class, with superlative medical care available to the wealthy and 45 million without health insurance is already the reality in the United States. Canada is in danger of illustrating the second possibility in that an artificial “crisis,” generated by political choices disguised as economic necessity, has created a rationale to justify the introduction of for-profit medicine and insurance that, at minimum, will normalize class-based health care. The worst-case scenario is that ideologically driven experiments

with privatization in certain provinces will cause further loss of national sovereignty to make social policy, Medicare will be shredded, and financial penalties will accrue due to NAFTA and GATS penalties.<sup>800</sup> The tragedy in Canada is that a system that was essentially working and that has the potential to provide efficient, quality, equitable health care is being systematically dismantled for profit by the few who will gain. Ironically, privatization, which is “the problem” as a quest for profits manifests in multi-tiered, costly, and often inferior medical care in the United States is being aggressively marketed as “the solution” to Canada’s difficulties by consulting firms, health economists, conservative politicians, and the “medical-industrial complex” (Relman 2002: 31).

Physicians are not the only ones advocating for-profit medicine and they are not the only coolers and zombie-masters in health care reform initiatives. Their behavior and their rhetoric does bear particular scrutiny, however, because of the unreflective way in which physicians often argue for their own perceived self-interests, such as commodified medicine, as if there were no consequences for real people in their demands. For a profession that often makes pious statements about “evidence-based medicine,” it is remarkable how often the rhetorical statements of organized medicine are widely divergent from plausible evidence as shown in numerous illustrations throughout this dissertation. A capacity for “willful ignorance” is dangerous when combined with cultural, social, and professional authority that often privileges the perspectives of physicians in matters relating to health and health care systems. Disingenuous statements such as discussions about bills that may be therapeutic for patients or that fee-for-service is intrinsic to the integrity of the doctor-patient relationship or that practice patterns are not affected by reimbursement incentives or that lacking health insurance is not the same as lacking health care are all self-serving propositions. Authoritative defenses of market medicine by well-esteemed physicians

hide a symbiotic relationship between for-profit medicine and for-profit insurance which serves the wealthy and the healthy while the unwealthy and unhealthy become even more so.

The fracturing of health care systems into multi-tiered layers with access and quality of care contingent on class mirrors the bifurcation of communities that are increasingly polarized by income and wealth inequalities. Just as the winners and losers of globalization are winnowed into gated communities and shantytowns globally, the haves and have-not have grown further apart in the United States and Canada. The association of income inequalities and social gradients with poorer health means that more demand for health services will be generated just as those most likely to need medical care, the under-classes, will have less access as formerly available publicly funded health services are delisted and privatized. Treating suffering, disease, and death just as other components in a product line within the logic of health care as a commodity erodes social capital. Privileging charity as the norm instead of social justice by not believing and acting as if health care is a human right further disintegrates social cohesion. Diminished social networks, solidarity, social capital, and social cohesion all have deleterious impacts on health. Alienation experienced by people as they attempt to navigate increasingly fragmented and complicated health care systems that consistently reinforce their worth calibrated by class further diminishes wellness. These are some of the outcomes that organized medicine, and all proponents of neoliberalism, need to acknowledge if they are going to advocate for market fundamentalism in a forthright fashion.

While intellectual integrity, altruism, and solidarity would all be good reasons for physicians to be attentive to the logic of market medicine and dynamics of globalization, there are also reasons associated with enlightened self-interest. A pragmatic argument in favor of rejecting health care as just another market commodity



lies within the model of physicians as citizen, family members, and friends. A recent National Public Radio story on how even geriatricians “have trouble making the health care system work for their own parents” (Shapiro 2004) is a reminder that dysfunctional, fragmented systems can fail even physicians and those they care about.

For-profit medicine may seize certain opportunities presented by globalization. High-income physicians that were once concerned about potential investment losses that could be attributed to casino capitalism and gamesmanship of corporate scams, now find that they might need to be worried about out-sourcing. As one radiologist put it: “Who needs to pay us \$350,000/yr if they can get a cheap Indian radiologist for \$25,000/yr (Pollack 2003). Other candidates for medical services that may be outsourced are “the analysis of tissue samples,<sup>801</sup> the reading of electrocardiograms, the monitoring of intensive care units and even robotic surgery” (Pollack 2003). While it remains to be seen whether the prediction of the number of radiologists declining significantly in the United States within five years will come true, the market medicine logic of roaming capital finding well educated workers in Asia willing to work for a fraction of American wages using inexpensive, high-bandwidth communication is impeccable within the ethos of market fundamentalism (Schumer and Roberts 2004).

While working within a commodified system that treats people on the basis of ability to pay rather than medical need may provide pecuniary rewards congruent with physicians’ self-regardingness, other emotionally satisfying or technically challenging elements may be missing. A highly paid physician diagnosing a cold in a boutique practice is still just diagnosing a cold. In addition to the previously discussed problem of decreased access for patients when medical expertise follows dollars rather than need, the under-utilization of intelligent, highly skilled physicians may lead to ennui. It is also ironic that burnout may occur in situations where some physicians feel overwhelmed with arduous clinical workloads and deteriorating quality of life at the same time that

they have steadfastly resisted working with nurse practitioners. Multi-disciplinary health care teams that share responsibilities for patient care based on their particular professional training, skill set, and personality could be a more satisfying and “creative” approach to health care reform than “creative” for-profit incentives. Teaching and mentoring other health care workers while caring for a caseload that demands a more challenging range of professional responses combined with improved possibilities for professional development and leisure time might help to offset giving up fee-for-service compensation for some physicians.

While access to health care is an important determinant of health, the perpetual framing of health care reform as limited to the biomedical box of Exhibit 2.2 severely limits discursive possibilities. So much attention gets devoted to the provision of medical services, as even is apparent in this dissertation, than the broader determinants of health are perpetually neglected. Still, a close examination of health care systems in the United States and Canada at the turn of the millennium has been instructive in revealing underlying values that seem to underpin some aspects of the health care systems as a microcosm of larger societal contexts. Organized medicine is complicit with the propagation of market fundamentalism, which undermines health and health care. Accruing professional capital for one’s own benefit is consistent with for-profit medicine but it fractures other human bonds that are not economic.

## ENDNOTES

1. John Griffin (2004) writes "President Bush once called Canadians 'our most important neighbors to the north' as if we had many others up there." Molly Ivins (2004) also cites this comment as part of a litany of "abuse" where living in such proximity to the United States is "like having the Simpsons for next-door neighbors."
2. The following quotation is useful both for its reiteration of the common claim of the "greatest medical care" and for its illustrative rant against "socialized medicine:" "Socialized medicine? No. Today, if you have to get sick any place in the world, get sick here in this country. We have the greatest medical care of any country in the world. And those countries that are practicing socialized medicine, the quality of the care has declined, the waiting list is forever, and the cost is far greater than it is here. In spite of the recent escalation in medical practice charges, the cost is greater. I believe that -- provide medicine and medical care for those people who cannot afford it for themselves, as we're doing. But the rest of it should be right out there in private enterprise, the same as we do everything else." President Ronald Reagan, October 10, 1984 This response was to a question posed by John Peltz during a Question-and-Answer Session at St. Agatha High School in Detroit, Michigan on October 10, 1984. The question posed by Peltz was "Mr. President, do you favor a national health program? Why, or why not?" Reagan responded: "When you say national health program, do you mean just encouragement of health or socialized medicine?" Peltz: "Socialized medicine" (Reagan 1984).  
<http://www.reagan.utexas.edu/resource/speeches/1984/101084b.htm>
3. *Die Medizinische Reform, Eine Wochenschrift*, Berlin, von Reimer Verlage July 10, 1848-June 29, 1849 as cited in (Taylor and Rieger 1985: 548).
4. Health is a contested concept in terms of diverging views of its constitutive elements and meanings. Characterized as being "honoured in repetition, but rarely in application" (Evans and Stoddart 1994: 28), the World Health Organization (WHO) defined health in its 1946 Constitution as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury." This positive definition of health is a rejection of a negative concept of health characterized by "the absence of disease or injury" which is the "definition of health implicit in (most of) the behaviour of the health care system" (Evans and Stoddart 1994: 28).
5. My understanding of ideology has benefited from consulting Michael Shapiro's chapter on "The Problem of Ideology: Locating the Political Analyst/Writer." Shapiro takes as his point of departure Theodor Adorno's definition of "unideological thought is that which does not permit itself to be reduced to 'operational terms' and instead strives solely to help the things themselves to that articulation to which they are otherwise cut off by the prevailing language" (Adorno 1981: 29). The helpful illustration that Shapiro provides uses the example of a diamond ring. Thinking unideologically, this ring may be both a status symbol and a sign of marital commitment. Thinking ideologically, in the

diamond merchant DeBeer's operational terms, this same ring is "forever" (Shapiro 1988: 6).

6. Joan Scott describes Michel Foucault's use of discourse as "a historically, socially, and institutionally specific structure of statements, terms, categories, and beliefs." Elaborating meaning involves power and conflict contestations. Competing claims are rooted in scientific knowledge in writing as well as in disciplinary and professional organizations, in institutions, and in social relationships (Scott 2001a: 256).
7. Vasco Nunez de Balboa (1475-1519). David Stannard documents how racism and Christianity underpin the genocide of the indigenous peoples of the New World in his book, *American Holocaust: The Conquest of the New World*. Christianity is directly implicated as he describes the missions as "furnaces of death" (1992: 137). The Council of Fourteen, selected by Charles V as "the best minds in Spain," agreed (with one exception) that "the Indians were indeed divinely created beasts of burden for their conquerors" (Stannard 1992: 211). There was some debate about whether God was punishing the Indians for their sins or the Spanish for their cruelties but "both sides in this ecclesiastical debate were agreed that God wanted the Indians dead" (1992: 219).
8. A thoughtful analysis of the theological roots and implications of antigay activism by the Christian Right in the United States may be found in *The Antigay Agenda: Orthodox Vision and the Christian Right* (Herman 1997).
9. The Westboro Baptist Church website ([www.godhatesfags.com](http://www.godhatesfags.com)) provides many examples. Their premise is the "only lawful sexual connection is the marriage bed. All other sex activity is whoremongery and adultery, which will damn the soul forever in Hell." Their handout entitled "Outlaw Sodomy" (dated December 3, 2002) includes photographs of Westboro Baptist Church picketers holding signs reading "God hates fags" and "Matt in Hell." This handout begins: "All nations must immediately outlaw sodomy (homosexuality) & impose the death penalty!"
10. Examples of physical violence range from the individual account of the October 1998 torture and murder of 21 year old Matthew Shepard in Laramie, Wyoming (Kaufman and Tectonic Theatre Project 2002) to the cumulative picture found in the national Uniform Crime Reporting Program statistics for hate crimes. In 2001, there were 1,103 offenses that were characterized as anti-male homosexual hate crimes by 1,196 known offenders (Federal Bureau of Investigation 2002: 9). This included 1 murder/nonnegligent homicide, 151 aggravated assault offenses, 335 simple assaults and 322 offenses characterized as intimidation (Federal Bureau of Investigation 2002: 12).
11. William Pryor, Alabama's attorney general and candidate for a federal judgeship, provides another example. He is well known for his "brief before the Supreme Court arguing that if a law in Texas outlawing sex between homosexuals was overturned, it would open the way for legalized 'prostitution, adultery, necrophilia, bestiality, possession of child pornography and even incest and pedophilia'" (Lewis 2003).

12. This American example is not to suggest that Canada has a placid relationship between church and state. Roman Catholic Bishop Fred Henry of Calgary warned that Prime Minister Jean Chrétien's support for same-sex marriage legislation could land him in hell. On July 30, 2003, Henry said: "He doesn't understand what it means to be a good Catholic," Bishop Fred Henry of Calgary said in an interview. "He's putting at risk his eternal salvation. I pray for the Prime Minister because I think his eternal salvation is in jeopardy. He is making a morally grave error and he's not being accountable to God" (Lunman 2003). Just for historical perspective, the first Catholic and French Prime Minister of Canada, Wilfred Laurier (1841-1919) "was branded an anti-Christ by ultramontane clerics of Quebec" (Zolf 2003) for not supporting a bill to restore Manitoba's Catholic schools. Prime Minister Pierre Elliot Trudeau (1919-2000), who was also Catholic, faced a "firestorm" with his omnibus bill in 1967 that "dealt with gays, abortion, and divorce" which prompted his statement: "The state has no place in the bedrooms of the nation" (Zolf 2003).
13. Thomas Coburn is an obstetrician who left Congress in 2000 after serving three terms representing his constituency in Oklahoma. The advocacy group, SIECUS (Sexuality Information and Education Council of the United States), points out that during his tenure in Congress, Coburn was a "fierce opponent of reproductive health and a staunch supporter of abstinence-only education" (SIECUS 2002: 1). Focus on the Family and the Family Research Council lobbied hard in support of Coburn's appointment as either the new U.S. Surgeon General or co-chair of PACHA.
14. A similar point could be made about Senate Majority Leader Bill Frist (R-Tenn.) who is a surgeon. He was denounced by the Human Rights Campaign for his remarks on June 29, 2003 on ABC's "This Week," in which he criticized the Supreme Court decision banning state sodomy laws, saying that it could lead to increased prostitution and drug dealing (Human Rights Campaign 2003).
15. Dehumanization of others and desensitization of the self are two essential elements in "genocidal mentality" (Vanderhaar 1984: 177). Language is a significant way of softening the harder edges of reality. "Language Rules" of the Nazis included "special treatment" instead of killing within official correspondence and "Final Solution" as the code phrase for extermination millions of people (Vanderhaar 1984: 179). "Final solution" was also used by proponents of Hutuness which resulted in the deaths of 800,000 Tutsis in Rwanda in 1994 (Gourevitch 1998: 94). Chilling examples of dehumanizing and desensitizing propaganda against gays and lesbians may be found at <http://www.godhatesfags.com>
16. Daniel Greenberg makes the argument that science "seeks public support for more money for science, without public interference in the use of the money" (2001: 207). When the public gets obstreperous, as ACT-UP did in the early years of the HIV pandemic (see for example (Shilts 1987) and (Burkett 1995)), one could see that as a clear refutation of a claim that "medical research has been traditionally free from political influence." In 1998 as "various patients' lobbies clamored for more money for research on *their* disease, and more influence over its use at NIH," a Council of Public Representatives was created at NIH (Greenberg 2001: 208). Citing HIV activist pressure on the Food and Drug Administration to fast track approval for medication, increased participation of

patients in scientific meetings, and shifting the balance of power in doctors' offices to a model of doctor-patient collaboration, Abigail Zuger argues "AIDS has been the first disease on record to spawn a huge, visible, angry grass-roots patients' rights movement that managed to change the course of medical history" (2003). The general premise that science has historically been distinct from politics also arguably reflects aspiration more than reality even if one restricts a discussion of the political to partisan politics. Richard Nixon's "animus towards scientists" (Greenberg 2001: 164) was expressed in rants against his science advisors, demands to cut off federal funding for the Massachusetts Institute of Technology as a site of antiwar activity and a MIT president who had conspicuously worked for John Kennedy, and banishment of what Nixon viewed as "vipers in the White House" (Greenberg 2001: 175). President Nixon issued an executive order in January of 1973 which effectively terminated the position of special assistant to the president for science and technology, the White House Office of Science and Technology, and the President's Science Advisory Committee (Greenberg 2001: 175-176). Greenberg draws an analogy between Nixon's dismantling of the White House Office of Science and Technology due to perceived disloyalty to presidential causes to the abolishment in 1995 by congressional Republicans of Congress's research agency, the Office of Technology Assessment, for its criticism of Ronald Reagan's Strategic Defense Initiative (Greenberg 2001: 288-290). George Shultz, secretary of state in the Reagan administration, scolded a surprised dinner audience at the National Academy of Sciences after 2,300 university researchers pledged they would not apply for or accept funds to work on the Strategic Defense Initiative. Schultz told his audience: "scientists should not expect their words to have special authority in non-scientific areas where they are, in fact, laymen...the core issues in dispute here are really not technical, but political and moral" (Greenberg 2001: 286). Greenberg notes the most notable foray of science into partisan politics occurred during the 1964 presidential campaign under the banner of Scientists and Engineers for Johnson-Humphrey. This organization enrolled more than 50,000 scientists and engineers who were aghast at the thought of a "trigger-happy" Barry Goldwater at the nuclear helm. "Denounced by the superstars of science and medicine, Goldwater was indelibly tarred as an irresponsible nuclear cowboy" (Greenberg 2001: 157). The beloved Dr. Benjamin Spock's support for Johnson was seen as especially devastating for Goldwater as "millions of American mothers and grandmothers in the United States would as soon question Dr. Spock as they would holy writ" (Greenberg 2001: 155).

17. The Traditional Values Coalition states that it represents more than 43,000 churches. Andrea Lafferty, executive director for the coalition said, "What makes us unique among all the conservative groups, is that I believe we truly represent the body of Christ." Discussing the list of scientific researchers that she personally gave to Representative Billy Tauzin, Lafferty "acknowledged that her group has a problem with homosexuality. 'We're concerned that it's a behavior-based lifestyle, that you're not born that way. She insisted that the coalition does not oppose research on HIV and AIDS, but added, 'How many times do you have to study something to find out how to stop the spread of AIDS.'" Dr. Julie Auerbach, vice president of the American Foundation for AIDS Research and previously head of the Office of AIDS Research at the National Institutes of Health stated, "The list itself is less important than the context in which it's been generated. The context is that in recent months there have been a series of specific inquiries to the NIH from Congressional committee members, through

their staffs in particular, asking about specific grants and specific grantees based apparently on the content of those grants. Those inquiries come in a very negative tone. And they cast aspersions on the quality and content of the science—from someone who doesn't know how to conduct science, and is not a scientist. So the NIH has been put in the position frequently in the last year of having to re-justify research that has already been peer-reviewed, approved and funded" (Herbert 2003).

18. Warren Magnusson describes militant Christianity as the mirror image of militant Islam and situates both of these in the same category as militant liberalism or secular humanism. Each tradition is at odds with the others due to competing claims of universal truth. Dominant assumptions that are common to monotheism are a "metaphysic of unity" and the "logic of identity." Monotheists seek to understand the Oneness or unity of God; science is a method to try to understand the laws of nature. In a post-Christian era repudiating God does not hinder basic assumptions about the metaphysical unity of all things. The search for "the truth" or "the one way" to solve problems is analogous to the search for one way to God. The purpose of science, within the metaphysical assumption of the logic of identity, is to decode and represent the essence of that which is being studied. This involves "putting everything in its proper place" through the use of dualisms and hierarchies. The promise that "we will know what every thing and every person has to be in order to be true to its own essence" is described by Magnusson as "the totalitarian vision promised by true science" (1996: 40-42).
19. Some of the consequences of the metaphor of vertical distance and chosen people include ranking human above the rest of nature (speciesism); men above women (sexism); whites against nonwhites (racism); upper classes against lower classes (exploitation); His People against the others (nationalism, imperialism); and True Believers against heretics, pagans (meritism, Inquisition) (Galtung 1990, 1998).
20. A report by the minority staff of the House Committee on Government Reform states that the Bush administration "persistently manipulates scientific data to serve its ideology and protect the interests of its political supports." This reports criticizes the Bush administration's advancement of "an unproven 'abstinence only' agenda" and the abolishment of a Centers for Disease Control and Prevention initiative that listed scientifically validated safe-sex techniques that included condom-use (Marquis 2003).
21. On May 16, 2003 the Senate approved Bush's \$15 billion AIDS initiative, described by the *New York Times* as "a legislative trophy" and by Bush as "as a symbol of the great depth of compassion that our country holds for those who suffer" (Stolberg 2003a). This bill included a requirement, inserted by House conservatives, that a third of the money for HIV prevention go to programs that promote abstinence until marriage (Stolberg 2003a). President Bush's five-year, \$15 billion AIDS plan is reported to be modeled after a program in Uganda, which stresses abstinence, monogamy and condom use. Visiting an AIDS clinic in Entebbe, Uganda, Bush managed to militarize healing by his rhetoric: "I met generals in the armies—in the worldwide army of compassion" (Associated Press 2003a).

22. A different illustration that features many of the same people associated with the Christian Right's response to HIV/AIDS may be found in discussions to ban dilation and extraction procedures (termed "partial-birth abortions" by some activists). Senator Rick Santorum is a leading proponent of a bill that would include fines and prison terms of up to two years for physicians who perform the procedure (Hook 2003). President Bush said that he would look forward to the signing ceremony for this bill as the legislation "will end an abhorrent practice and continue to build a culture of life in America" (Stolberg 2003b). Senate majority leader and surgeon, Bill Frist, said after the Senate vote: "The legislation we just passed will save lives. We have just outlawed a procedure that is barbaric, that is brutal, that is offensive to our moral sensibilities and it is out of the mainstream of the ethical practice of medicine today" (Stolberg 2003b). Critics of the bill, including the American College of Obstetricians and Gynecologists oppose this ban as they find the legislation was so broadly written that it could outlaw a wide range of common abortion procedures. Senator Barbara Boxer, who led the fight against the bill, notes "For the first time in history, Congress is banning a medical procedure that is considered medically necessary by physicians. This is a radical, radical thing that is about to happen" (Hook 2003).
23. A compelling case for the poverty of causality claims in the social science, public health, and clinical medicine literature with respect to HIV/AIDS has been made by authors associated with Partners in Health (Farmer, Connors, and Simmons 1996).
24. "In a widely noted 1996 diatribe against his fellow billionaires, Ted Turner blamed the *Forbes* 400 list for plutocratic stinginess. 'That list is destroying our country!' he complained to the *New York Times*. 'These new superrich won't loosen up their wads because they're afraid they'll reduce their net worth and go down on the list. That's their Super Bowl!'" (Conniff 2002: 102). Conniff explains part of the dynamic of philanthropy of Ted Turner, Bill Gates, and Rupert Murdoch as a form of competitive conspicuous consumption to demonstrate social dominance. During an interview with Barbara Walters on the ABC news show *20/20* a few months after Turner's donation to the United Nations, Gates said, "Well, I think Ted is great. And I'm very glad he has given that billion dollars. Certainly my giving will be in the same league as Ted's, *and beyond*" (Conniff 2002: 114). Those seeking funds are not shy about taking advantage of "a sort of arms race among potential donors. Thus Harvard University did not merely tell Albert J. Weatherhead III that he was 'Harvard's third largest living donor,' but also shamelessly added, 'and you won't rest until you are No. 1'" (Conniff 2002: 106).
25. The partner institutions in the Global Polio Eradication Initiative are WHO, UNICEF, and Rotary International. Photograph and texts accessed May 29, 2003: <http://www.gatesfoundation.org/StoryGallery/>
26. The Bill and Melinda Gates Foundation website states that "the foundation was created in January 2000, through the merger of the Gates Learning Foundation, which worked to expand access to technology through public libraries, and the William H. Gates Foundation, which focused on improving global health." Accessed on October 26, 2003: <http://www.gatesfoundation.org/AboutUs/>



27. The World Bank's influential *World Development Report 1993: Investing in Health* has been highlighted as a landmark document signaling a shift in international health leadership from the World Health Organization to the World Bank (Buse and Gwin 1998: 666).
28. The language of "structural adjustment," known as "conditionalities" by economists, has been replaced by "poverty reduction strategies" by the World Bank and IMF. The former chief economist of the World Bank, Joseph Stiglitz, describes the Assistance Strategy specially designed for each country as each nation's economy is individually analyzed then "the Bank hands every minister the exact same four-step program" (Palast 2003: 153). The steps are privatization ("briberization"); Capital Market Liberalization (change national laws to allow capital flows); Market Based Pricing (raise prices on food, water, fuel) and "poverty reduction strategies" (free trade as ruled by the WTO and World Bank) (Palast 2003: 154-158).
29. Schoepf et al articulate their concern as "the 'short-term pain' of SAPs means that for many poor Africans *there will be no long term*" (2000: 125).
30. Indicators of the Human Development Index include life expectancy at birth, adult literacy rate, combined primary, secondary, and tertiary gross enrolment ratio, GDP per capita, life expectancy index, and education index, and GDP index.
31. The "failure of capitalism" exchange comes just prior to the passage cited within the text: "**MOYERS:** What does it say to you that of the 4 million babies who die within their first month, 98 percent are from poor countries? What do those statistics tell you about the world? **GATES:** It really is a failure of capitalism. You know capitalism is this wonderful thing that motivates people, it causes wonderful inventions to be done. But in this area of diseases of the world at large, it's really let us down" (Moyers 2003).
32. Bill Gates's home is 66,000 square feet on five acres. The total assessed value was \$53,392,200 and the land is valued at \$9,122,200. Accessed May 31, 2003: <http://www.usnews.com/usnews/nycu/tech/billgate/gatehigh.htm>
33. This compound used 4.7 million gallons of water in the year 2000 compared with the average house in Medina that used 80,000 (Conniff 2002: 174).
34. In January, 2002, the number of people needing shelter in Toronto was 5,000 per night, five times the average number 10 years ago (Day 2002). The first national snapshot of homeless people in Canada indicated 14,145 people as being homeless in 2001 (Yourk 2002). On any given day in the United States, more than 800,000 individuals are homeless, including about 200,000 children. In a given year in the late 1990's, estimates range from 2.3 million to 3.5 million people experience homelessness in the United States sometime during an average year (Burt 2001). In the United States, a 27 city survey found that 81 percent of the cities surveyed registered an increase in those seeking emergency shelter, by an average of 13 percent from 2000 to 2001. Requests from homeless families increased by 22 percent, with 73 percent of the cities reporting an increase (United States Conference of Mayors 2001: 40-43).

35. Requests for emergency food assistance increased from 2000 to 2001 by an average of 23 percent, with 93 percent of the cities reporting an increase (United States Conference of Mayors 2001: 6). Second Harvest in Chicago, which coordinates food distribution to 212 food bank warehouses, reported that it is seeing three times more clients than before September 11, 2001 (Kilborn 2003). The Census Bureau reported that 12 million families in the United States were worried in 2002 that they did not have enough money for food. There were an estimated 567,000 hungry children in the United States in 2002 (Associated Press 2003f).
36. Homelessness was the subject of a recent editorial in *Glamour* magazine in March 2003 (No Place Like Home 2003).
37. A recent report documents the increasing common practice of arresting people for life-sustaining activities such as sleeping, resting, storing belongings, and activities related to personal hygiene in public places. In San Francisco, 43,000 people were cited in one year for "quality of life" violations. In Baltimore, people experiencing homelessness spend an average of 35 days per year in jail (National Coalition for the Homeless and National Law Center on Homelessness and Poverty 2002: 15).
38. The Constitution of the World Health Organization states that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition" (1946). Canada and the United States are both Member of the World Health Organization. Canada became a party to the Constitution on 29 August 1946 and the United States joined on 21 June 1948 (WHO 2000).
39. While stipulating that health is determined by multiple determinants in addition to access to medical care, the most egregious example often given when speaking of "right to health" dilemmas in North America is access to medical care in the United States. The Census Bureau estimated that there were 43.6 million people in the United States who were without health insurance in 2002. This is an increase of 2.4 million people from 2001 or a proportional increase from 14.6% in 2001 to 15.2% in 2002 (Pear 2003a). The Robert Wood Johnson Foundation reported "nearly one in three Americans" (30.1%) did not have health insurance for all or part of 2001 and 2002. They estimate 74.7 million people under the age of 65 years in the United States were without health insurance; of these, almost two-thirds were uninsured for six months or more (Families USA Foundation 2003).
40. Richard Stallman, founder of the free-software movement made the analogy that donating Windows computers to schools is "like giving them gratis packs of cigarettes: a plan to get them hooked" (Andrews 2003).
41. James Love observed "the impression people have, because of the types of projects Gates has funded and because of his Microsoft background, is that he has an ax to grind on the intellectual-property front" (Bank and Buckman 2002).
42. (United Nations Development Programme 2002: 192)

43. (United Nations Development Programme 2002: 151)
44. (UNAIDS/WHO 2002: 16)
45. Journalist Greg Palast describes the relationship between the Gates Foundation and the drug industry as “working paw-in-claw with Merck and other Big Pharma corporations tied to a PR campaign that drowns out the calls of doctors pleading to end TRIPS restrictions. If there’s any doubt where the Gates’s hearts lie, the *Wall Street Journal* notes that their foundation has, oddly, invested over \$200 million in drug company stocks. If this “charitable” operation eviscerates protest against the TRIPS thought-police and medical patents are upheld, Gates’s donations could have the effect of killing more people than they save” (Palast 2003: 190-191).
46. The *Wall Street Journal* more diplomatically suggests that “managing the foundation’s multiplying ties with the drug industry could get tricky” (Bank and Buckman 2002).
47. Another example of the hegemony of this approach was the nomination by President Bush of Randall Tobias to head a \$15 billion program to fight AIDS worldwide from a new office at the State Department. Mr. Tobias has no experience with HIV issues or with Africa, but he is the former chair and chief executive officer of Eli Lilly & Company (Bumiller 2003).
48. The World Economic Forum which took place in Davos, Switzerland was described as follows: “The six-day forum brought together 2,311 people—including 24 heads of state, 177 academics, and 1,300 business leaders. The theme of this year’s meeting was “Building Trust”. Klaus Schwab, founder and president of the World Economic Forum, said that the success of the meeting “was a sign that confidence might be cautiously returning to a world shaken by economic insecurity, corporate scandals, and terrorism” (Ashraf 2003: 404).
49. Critiques of medical care as colonialism and imperialism are not new. Frantz Fanon describes the ambivalence provoked in “the native” by Western medical science as “part of the oppressive system” introduced into Algeria at the same time as racialism and humiliation (1978: 229). Richard Brown tackled imperialism and public health (1978) and James Paul may be consulted about imperialism and medicine (1978).
50. Donors expect to see results for their charity and outcomes of targeted interventions or “vertical programs” are easier to quantify than “horizontal” or “integrated” programs such as primary health care. J. Cohen cites the “recent WHO obsession with the disease triad (AIDS, malaria, and tuberculosis)” as representative of the dynamics of the vertical disease approach. Although such programs may attract donors, they are often only sustainable for the duration of donor support and they divert financial and human resources from the health system (2003: 876).
51. Writing of the political implications of primary health care, David Werner, author of *Where There Is No Doctor*, suggests an alternative to the technical perspective: “...as people look more deeply into the reasons for their ill-health, they recognize that sickness, disease, and malnutrition are merely symptoms of a

deeper malady stemming from social inequality, economic exploitation, and political oppression. PHC in the true sense threatens inequitable socioeconomic or political structures. It implies a redistribution of responsibility and power of a much more radical kind than is generally realized or accepted. It means shifts in power from top to lower levels of government administration; from the government itself to people's organizations; from military to civilian administrations; from doctors to paradedics; from health professionals to ordinary people; from the village elite to landless and marginal farmers; and from men to women" (Morley, Rohde, and Williams 1983: 321-322).

52. In keeping with semi-divine status, Bill Gates received lengthy applause from alumnae of the Indian Institute of Technology who agreed with Rajat Gupta as he told Gates: "It is your light that leads us" (Andrews 2003).
53. While acknowledging Bill Gates's "plunges into charity" coincided in time with the federal anti-trust lawsuit, Gates is praised by various sources as "a guy with a vision." "Bill Gates is going to be remembered more for what he did for international public health than what he did for the world of computers," predicted Richard T. Mahoney, a professor at Arizona State University who has wide experience dealing with health issues in poor countries" (Strom 2003b).
54. Howard Waitzkin has a degree in medicine and a doctorate in sociology from Harvard University. He is the author of *The Second Sickness: Contradictions of Capitalist Health Care*. New York: The Free Press (1983). Waitzkin is Professor and Director, Division of Community Medicine, Department of Family and Community Medicine and Professor of Sociology at the University of New Mexico.
55. Jon Hamilton disclosed Gates Foundation funding for National Public Radio in the context of his story but disclosure of Gates Foundation for the Moyers-Gates broadcast did not seem to me obvious either within the interview transcript or the pbs.org website.
56. I am indebted to Deane Neubauer for raising the point of liberalism's core principle of individualism raising the question of what to do with individuals above the market. Personal communication, October 14, 2003.
57. (McQuaig 1998: 249) George Soros writes that "social Darwinism" is intrinsic to the "capitalist threat:" "By taking the conditions of supply and demand as given and declaring government intervention the ultimate evil, laissez-faire ideology has effectively banished income or wealth redistribution" (Soros 1997).
58. Richard Conniff portrays Ted Turner's gift of \$1 billion to the United Nations (\$100 million per year for 10 years) as both generous (this was a third of Turner's net worth) and self-serving. As Turner himself, "I have learned the more good I do, the more money has come in" (Conniff 2002: 104). By the middle of 2001 Turner was worth an estimated \$9 billion; of that, \$3 billion came from a one day "boost" from the Time Warner AOL merger that escaped the antitrust difficulties that plagued Microsoft (Conniff 2002: 115-116).
59. (Kafala 2000)

60. Marc Eisner describes the history of regulations in the United States since 1880 as a sequence of “regulatory regimes” created in response to economic changes that threatened perceived self-interest of various groups. The **market regime** emerged during the growth of large-scale corporate economy and national markets from 1880 to 1920. The **associational regime** promoted industrial stability and redistribution of national income through New Deal initiatives during the Great Depression. The **societal regime** reflected quality of life concerns and “postmaterialist values” associated with the social movements of the 1960s and 1970s. The **efficiency regime** arose in the context of stagflation and increased foreign competition of the 1970s and 1980s. Arguing that excessive regulation contributed to poor economic performance, this regime sought to eliminate policies that interfered with market mechanisms or that imposed large compliance costs (Eisner 2000: 1-9).
61. The exact quotation is: “Great Men and ordinary people lived their lives with the constant presence of death, and the astonishing fact is that this was so until almost the twentieth century. One quarter of children died in the first years of their lives, and life expectancy was only thirty years. How can we even image the bleakness of the lot of the average person?” (Golub 1997: 13)
62. Additional support for nonspecific mortality may be found in the Whitehall Studies. In Whitehall I, a prospective study of 17, 530 British civil servants, there was a steep inverse relation between occupational grade and mortality. The age-adjusted mortality rate over a ten-year period for men aged 40 to 64 years was three and a half times higher for those in the lowest grade than for those in the highest grade of senior administrators (Marmot, Shipley, and Rose 1984). All the men in the study were in stable, sedentary jobs with little exposure to industrial hazards and all had access to medical care through the National Health Service. The Whitehall II study, with a new cohort of 10,314 male and female civil servants aged 35 to 55, found that during the intervening twenty years, “there has been no diminution in social class difference in morbidity: we found an inverse association between employment grade and prevalence of angina, electrocardiogram evidence of ischaemia, and symptoms of chronic bronchitis” (Marmot et al. 1991:1387). Robert Evans, commenting on these studies, pointed out that none of the participants were impoverished or deprived and that the main point of these findings is that “...there is *something* that powerfully influences health and that is correlated with hierarchy per se. It operates, not on some underprivileged minority of ‘them’ over on the margin of society, to be spurned or cherished depending upon one’s ideological affiliation, but on all of us. And its effects are *large*.” (Evans 1994: 6). Evans suggests that when considering the relative risk of death from coronary heart disease that even after adjusting for smoking and other “individual” risk factors, that much is left unexplained: “On average, people in the lower grades were at greater risk for heart disease because they had higher levels on the established triad of smoking, blood pressures, and cholesterol. But differences in mortality from heart disease persisted after adjustment for all these factors. These observations suggest some underlying general causal process, correlated with hierarchy, which *expresses* itself through different diseases. But the particular diseases that carry people off may then simply be alternative pathways or mechanisms rather than “causes” of illness and death; the essential factor is something else” (1994: 7).

63. In an interview given in 2000, Dr. Foege discusses vaccination programs as being relatively easy to evaluate: "The success or failure of the children's vaccine initiative can be measured by the number of children being vaccinated" (McCarthy 2000: 155). A more difficult yet meaningful measurement would be overall pattern changes in morbidity and mortality linked with a multitude of health determinants.
64. Data from (World Bank 1993: 200-201). In the summer of 2003 I made numerous email and phone contacts to the World Bank to try to get updated median age of death statistics. What is worthy of being counted is as not-innocent is a further illustration of themes discussed in this dissertation. In his foreword to Paul Farmer's *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, Amartya Sen (2003: xi) uses the same 1990 data of the median age of death as less than 5 years with the comment: "That, I should explain, was the number in Africa in the early 1990's, before the AIDS epidemic hit hard, making the chances worse and worse. It is difficult to get reliable statistics, but the evidence is that the odds are continuing to fall from the already dismal numbers."
65. The complex and interrelated determinants of health in the Population Health framework as articulated by Health Canada include:
- income and social status
  - social support networks
  - education
  - employment/ working conditions
  - social environments
  - physical environments
  - personal health practices and coping skills
  - healthy child development
  - biology and genetic endowment
  - health services
  - gender
  - culture

Health Canada, Population Health Approach, accessed June 17, 2003  
[http://www.hc-sc.gc.ca/hppb/phdd/approach/approach.html#key\\_elements](http://www.hc-sc.gc.ca/hppb/phdd/approach/approach.html#key_elements)

66. See (Relman 1980) on the "medical-industrial complex" and (Neubauer 1984) on the similarities between the military-industrial complex and the medical-industrial complex. Eric Schlosser's essay (1998) on the "prison-industrial complex" makes a parallel argument for promises of public safety that corresponds to those of health and security.
67. Evans and Stoddart write: "Perhaps Ivan Illich is right, and the health care system as a whole has a net negative impact on the health of the population that it serves. But we do not know that, and we do not know how one could come to know it" (1994: 56).
68. Clinical iatrogenesis and the "limits of the possible" are not new concerns. Illich points out that Al-Razi (865-925 C.E.), medical chief of the hospital in Baghdad, was concerned with the medical study of iatrogenesis. "At the time of Al-Nadim

(A.D. 935), three books and one letter of Al-Razi on the subject were still available: *The Mistakes in the Purpose of Physicians; On Purging Fever Patients Before the Time is Ripe; The Reason Why Ignorant Physicians, the Common People, and the Women in Cities Are More Successful Than Men of Science in Treating Certain Diseases and the Excuses Which Physicians Make For This*; and the letter: "Why a Clever Physician Does Not Have the Power to Heal All Diseases, for That is Not Within the Realm of the Possible" (1976: 27).

69. Clinically speaking, Illich argues that many medical treatments are ineffective or harmful. Social iatrogenesis involves labeling people as deviant thereby generating income for the medical industrial complex while depoliticizing the effects of capitalism. For Illich, "cultural iatrogenesis" sets in "when the medical enterprise saps the will of people to suffer their reality" (1976: 127). Moving beyond recognition of a person's place within a specific economic, cultural, and political social order, the "killing of pain" erodes epistemic and ontological possibilities. In contrast with "medicalized death" as a sequela to a "medicalized life," Illich conceives of healthy people as follows: "Healthy people are those who live in healthy homes on a healthy diet in an environment equally fit for birth, growth, work, healing, and dying; they are sustained by a culture that enhances conscious acceptance of limits to population, of aging, of incomplete recovery and ever-imminent death. Healthy people need minimal bureaucratic interference to mate, give birth, share the human condition, and die" (1976: 274-275).
70. Primary prevention for drapetomania was kindness and whipping: "When sulky and dissatisfied without cause, the experience of those on the line and elsewhere was decidedly in favor of whipping them out of it, as a preventive measure against absconding or other bad conduct. It was called whipping the devil out of them. If treated kindly, well fed and clothed, with fuel enough to keep a small fire burning all night, separated into families, each family having its own house—not permitted to run about at night, or to visit their neighbors, or to receive visits, or to use intoxicating liquors, and overworked or exposed too much to the weather, they are very easily governed—more so than any other people in the world...They have only to be kept in that state, and treated like children, with care, kindness, attention and humanity, to prevent and cure them from running away" (Cartwright 2001: 103).
71. The complete quotation for this important point is as follows: "We come to see "health" as defined by what the physician is able to tell us: our concepts of health become increasingly defined by the physician's diagnostic technology, and ironically, as it grows more complex, we are led to believe our measurement of health increases accordingly. What we tend not to see, to be aware of, is the incremental shift from our personal assessments of the quality of our health, to the physician's technologically aided assessment of the quantitative measures of our health" (Neubauer 1984: 33).
72. Seeds for this table were planted by comparisons between traditional public health and new public health identified as part of a group effort in a graduate seminar on the Politics of Health, POLS 675F, University of Hawaii at Manoa, in Spring 1998. I also appreciate the helpful comments on this chart given by faculty and graduate students of an informal departmental writing group in April 2003 at the University of Hawaii.

73. "One needs to study what kind of body the current society needs" (Foucault 1980: 58).
74. Accessed October 27, 2003. Lesson plan to accompany "Health, Wealth, and Bill Gates" may be found at:  
<http://www.pbs.org/now/classroom/globalhealth.html>
75. A "poster child" is often emblematic of a vertical approach to disease. "Jerry's Kids," used for decades in the Jerry Lewis telethon to raise funds for the Muscular Dystrophy Association, would be an example of this kind of synecdoche where specific adorable children stand in for a more general predicament. Although Virchow could stand in as a cautionary tale for academic clinicians asked to be consultants for the state, his complex argument about etiology does not lend itself to individual targets for intervention or quick-fix solutions. A photogenic poster child with neuromuscular disease can press home the need for a new wheelchair or a new microscope for the laboratory but a compelling way to capture the desirability of "unlimited democracy" or progressive tax reform is a bit more challenging.
76. Virchow writes that "medical statistics will be our standard of measurement: we will weigh life for life and see where the dead lie thicker among the workers or among the privileged" *Die Medizinische Reform, Eine Wochenschrift*, Berlin, von Reimer Verlage July 10, 1848-June 29, 1849 as cited in (Taylor and Rieger 1985).
77. After losing his post at the Charite, Virchow accepted a chair position at Wurzburg University (Shryock 1936: 204). Characteristics that may have protected Virchow against repercussions from his outspoken views include his brilliance, vacuums left by the deaths of many of his outstanding peers in science, and his "talent of not making personal enemies of his scientific foes. Of course, it didn't hurt that he was a product of the military school; if he was a radical, he was *their* radical" (Golub 1997: 143).
78. Andrew Abbott writes that "the tasks of professions are human problems amenable to expert service" (1988: 35). He argues that the "essential cultural logic of professional practice" resides in the cognitive structure of diagnosis, inference, and treatment (1988: 40).
79. *Die Medizinische Reform, Eine Wochenschrift*, Berlin, von Reimer Verlage July 10, 1848-June 29, 1849 as cited in (Taylor and Rieger 1985: 548).
80. The description of "science at the prow and commerce at the helm" is a subtitle used by George Bernard Shaw (1856-1950) (Shaw 1950).
81. This point is courtesy of Deane Neubauer, private communication, July 22, 2003.
82. The most serious complaint about the Hôtel-Dieu Hospital cited in "Medicine in New France" was made by Andre Doreil, financial commissary of wars at Quebec from 1755 to 1758 who "extolled the sisters' merits, at the same time urging them to serve wine to patients so that hospital care in New France would match that of the mother country in every detail" (Gelfand 1987: 87).



83. "Mediascape" here is used in Arjun Appadurai's sense of the distribution of electronic capabilities to produce and disseminate information such as films, television, magazines, and newspapers. Appadurai suggests that "mediascapes, whether produced by private or state interests, tend to be image-centered, narrative-based accounts of strips of reality, and what they offer to those who experience and transform them is a series of elements (such as characters, plots, and textual forms) out of which scripts can be formed of imagined lives, their own as well as those of others living in other places. These scripts can and do get disaggregated into complex sets of metaphors by which people live as they help to constitute narratives of the Other and protonarratives of possible lives, fantasies that could become prolegomena to the desire for acquisition and movement" (1996: 35-36).
84. Alan Kors and Edward Peters situate dates for witch hunting from 1100 to 1700 and estimate the number of deaths from no less than 150,000 to perhaps triple this number (1972: 13). Ehrenreich and English's sources "estimated the total number killed to have been in the millions" (1973: 7-8). While the exact number of people killed is controversial in much the same way as conflicting estimates of the number of indigenous people decimated by contact with the Europeans, the misogyny of the Catholic Church is undisputed. *The Malleus Maleficarum* or "The Witch Hammer" of 1486 warns that "when a woman thinks alone, she thinks evil" (Kramer and Sprenger 1971: 43). After all, "what else is woman but a foe to friendship, an unescapable punishment, a necessary evil, a natural temptation, a desirable calamity, a domestic danger, a delectable detriment, an evil of nature, painted with fair colours!" (Kramer and Sprenger 1971: 43). Women are "naturally more impressionable," "have slippery tongues," are "more carnal," "by nature quicker to waiver in faith," wrathful, envious, "a wheedling and secret enemy," "have weak memories," and are "liar(s) by nature" (Kramer and Sprenger 1971: 43-47). In short, "a woman is beautiful to look upon, contaminating to the touch, and deadly to keep" (Kramer and Sprenger 1971: 46). Given all of these frailties "it is no wonder that so great a number of witches exist in this sex" (Kramer and Sprenger 1971: 45).
85. Charges against witches included devouring newborn babies, copulating with the devil, rendering men impotent, poisoned livestock and "crimes" that could be labeled as medical practices such as providing contraception measures, performing abortions, and giving drugs to ease the pain of labor (Ehrenreich and English 1978a: 35).
86. Ehrenreich and English omit from their discussion the New England witch trials that took place in Hartford in 1662 and then thirty years later in Salem Village as they "occurred on a relatively small scale, very late in the history of witch-hunts, and in an entirely different social context than the earlier European witch-craze (1973: 8). Norman Gevitz notes that there are 46 male physicians, surgeons, or apothecaries named in court transcripts or source documents relating to the New England witch trials (2000: 7). He makes the argument that doctors not only were the "principal professional arbiters for determining natural versus preternatural signs and symptoms of disease," they also held key judicial, administrative, and legislative roles related to witchcraft proceedings (2000: 7). Sometimes a diagnosis of diabolism followed lack of response to treatment as Harvard-trained Dr. Thomas Oakes (1644-1670) "found himself so affronted by the distempers of the children, that he concluded nothing but a hellish witchcraft

could be the origin of these maladies" (Gevitz 2000: 27). Dr. Crosby's "damning opinion" that James Carr was "behagged" by Mrs. Mary Bradbury is "particularly interesting because she was a midwife and healer and thus a competitor" (Gevitz 2000: 28). On the other side, Gevitz also argues that doctors may have ameliorated witch-hunting by delegitimizing some of the accusations such that they were never officially recorded. As with primary prevention in other contexts, it is always difficult to prove that which was averted.

87. For a compelling account of 150 years of experts' advice to women and "The "Sick" Women of the Upper Classes" see (Ehrenreich and English 1978a) (Ehrenreich and English 1978b). Emily Martin (1992) provides additional examples of cultural constructions of women's bodies by medicine. Ehrenreich and English cite this illustrative warning by Birmingham, Alabama physician, R. R. Coleman: "Women beware. You are on the brink of destruction: You have hitherto been engaged in crushing your waists; now you are attempting to cultivate your mind : You have been merely dancing all night in the foul air of the ball-room; now you are beginning to spend your mornings in study. You have been incessantly stimulating your emotions with concerts and operas, with French plays, and French novels; now you are exerting your understanding to learn Greek, and solve propositions in Euclid. Beware! Science pronounces that the woman who studies is lost" (1978a: 128).
88. Many medical articles are entitled on variations of "the Midwife Problem" rather than the "Infant and Maternal Mortality Problem," thus "reflecting the desire of physicians for the expansion of (their) profession and elimination of midwifery" (DeVries 1985: 26).
89. An alternative way to look at sexism, racism, and classism in the growth of obstetrics-gynecology as a profession is supplied by Deborah Kuhn McGregor who traces a history of J. Marion Sims, "the father of gynecology." Dr. Sims moved to New York City in the 1850s where he treated "mostly Irish women as patients" at the Women's Hospital he founded. Sims's specialty grew out of experiments that he and his colleagues did on immigrants, slaves, poor, and working class women (McGregor 1998). In fact, Richard Shryock dispassionately notes: "Local conditions, in the form of the 'peculiar institution' of slavery, were a factor in making possible Marion Sim's epoch-making operation for vesico-vaginal fistula (1849). Sims first experimented on slaves, and it is interesting to find him remarking that in one case he had to purchase his patient in order to operate upon her" (1936: 177).
90. A modern reader of the Flexner Report is often struck by how patients are consistently referred to as "material" and instrumentalized as fodder for pedagogical purposes: "Mere mass of material, swiftly handled, may be useful to experienced practitioners in affording a variety of cases among which occasionally something rare and interesting may turn up" (1910: 121).
91. Canadian physicians were no less judgmental. In 1931, an obstetrician who chaired the Canadian Medical Association's maternal morbidity committee, Dr. William Hendry, called midwives "a menace to the health of any woman whom they might attend"(Rachlis and Kushner 1994: 225).

92. Evidence that Canadian physicians also saw midwives as economic competitors is supported by a letter from a physician who wrote to the *Canada Lancet* signing himself as "A Correspondent:" "Describing his competition as being two women acting as midwives and one quack, he admitted they had 'been pretty successful in their attendance on (midwifery) cases. They charge \$2 (while I have \$5) for their attendance, and they get about 60 cases a year, which would amount in my hands to a very decent living for my small family" cited by (Mitchinson 1991: 169).
93. Data from several states collected from 1910 to 1930 on rates of infant and child mortality indicated that midwives performed as well as, or better than physicians (Devitt 1979).
94. "Unlike a midwife, a doctor was not about to sit around for hours, as one doctor put it, 'watching a hole': if the labor was going too slow for his schedule he intervened with knife or forceps, often to the detriment of the mother or child" (Ehrenreich and English 1978a: 97).
95. "Although physicians generally opposed midwife training programs, they supported such programs for midwives who worked in urban ghettos and among the rural Southern poor" (DeVries 1985: 27).
96. Some doctors bled women to unconsciousness in order to counter delivery pains. In a famous case in Boston in 1833 "a woman had convulsions a month before her expected delivery. The doctors bled her of 8 ounces and gave her a purgative. The next day she again had convulsions, and they took 22 ounces of blood. After 90 minutes she had a headache, and the doctors took 18 more ounces of blood, gave emetics to cause vomiting, and put ice on her head and mustard plasters on her feet. Nearly four hours later she had another convulsion, and they took 12 ounces, and soon after, 6 more. By then she lapsed into a deep coma, so the doctors doused her with cold water but could not revive her. Soon her cervix began to dilate, so the doctors gave her ergot to induce labor. Shortly before delivery she convulsed again, and they applied ice and mustard plasters again and also gave a vomiting agent and calomel to purge her bowels. In six hours she delivered a stillborn child. After two days she regained consciousness and recovered. The doctors considered this a conservative treatment, even though they had removed two-fifths of her blood in a two-day period, for they had not artificially dilated her womb or used instruments to expedite delivery (Wertz and Wertz 1994: 183).
97. Richard Harris reports that the AMA used the phrase "professional birth control" when proposing a restriction on the number of students in medical school as a response to a study done in the 1930s reporting that more than half the country's doctors had annual incomes of less than \$3,100 (Harris 1966: 13).
98. Shaw warned of the dangers of the "unqualified qualified" who would employ new techniques without proper training. He gives this example: "The truth is that X-ray cautery in the hands of any but a highly trained expert produces after a few days a burn beyond all comparison worse than a brand from the hottest of red-hot poker, and that the victim is to be heartily congratulated if, after months of atrocious pain, which only a reckless use of morphia can make bearable, the excision of the part leaves the patient boasting himself an interesting case of

“dermatitis” sooner than confess that he has been simply burnt by a bungler” (Shaw 1950: 39).

99. The AMA Code of Ethics of 1847 has seven points on “duties of physicians to patients” and ten points on “duties of patients to their physicians.” “The first duty of a patient is, to select as his medical adviser one who has received a regular professional education. In no trade or occupation do mankind rely on the skill of the untaught artist; and in medicine, confessedly the most difficult and intricate of the sciences, the world ought not to suppose that knowledge is intuitive” (Chapter 1, Art. II).
100. The phrase “a sovereign profession” is taken from Paul Starr (1982). As context for these metaphors of royalty and religion, this might be a pertinent place to situate the esteem afforded to physicians in the public imagination. The National Opinions Research Corporation’s polls in 1947 and 1963 showed that physicians ranked second after U.S. Supreme Court Justices for most prestigious occupation (Sennett and Cobb 1972: 221). Academic researchers designed a prestige poll that would be comparable to the National Opinions Research Corporation’s data which indicated an increased score of 86 in 1989 compared with 82 in 1964 for physicians (Simon 1992). “Respondents recognized that “scientists are well-educated vis-a- vis the rest of the population and are high-paid,” says study coauthor Treas. “Science as an institution is highly esteemed in American society.” In contrast, clergy slightly declined to 67 in 1989 from 69 in 1964 (Simon 1992).
101. William Osler (1849-1919) was held in the highest esteem by his patients, colleagues, students, and his biographer who complained “try as I might, I could not find a cause to justify the death of Osler’s reputation”(Bliss 1999: xiii). Bliss writes that “everyone knew Osler, and almost everyone loved him” (1999: x). Some of his students worshipped him as this male intern indicated: “We all worship him and if it would give Dr. Osler any pleasure to walk over me, I would lie on the ground and let him do it” (Bliss 1999: 237). Bliss says that “for them he was everything a physician should be—not only as a diagnostician and teacher and medical writer, but in demeanor, dress, manners, love of good books, Saturday-night sociability, and a near-religious commitment to medicine as a way of life” (1999: 228). After he died, British cabinet minister Herbert Fisher wrote to Mrs. Osler that “nobody ever lived who had to such a remarkable degree the gift of making other people feel that life was worth while...He appeared to those of us who met him in the ordinary transactions of life to be as perfect as it is given human frailty to be” (Bliss 1999: 480). Osler’s Library at McGill University “was a shrine, architecturally a cross between a church and a mausoleum” (Bliss 1999: 491). Bliss found this literally to be true: “I was working on this biography in the Osler Library, sitting at Osler’s desk, one day in September 1997 when a freshman student at McGill quietly slipped into the inner sanctum and, in an act of secular worship, places at the foot of the Osler plaque a bouquet of flowers and a card asking for Osler’s blessing on his studies”(1999: 499).
102. In the summer of 1897 Baptist minister Frederick Gates selected Osler’s *Principles and Practices of Medicine* to read over his summer holiday. Gates was impressed by how few diseases could be treated effectively. “Suppose medical research were to become more handsomely endowed: ‘We might expect,’ Gates wrote

Osler a few years later, 'in the next generation or two to reduce medicine...to something resembling an exact science, and we might reasonably expect results as revolutionary, as far-reaching, as beneficent on human well-being as any which have been derived from the practical applications of physical and chemical sciences" (Bliss 1999: 257). Gates wrote to his employer, John D. Rockefeller, urging support for medical research and the development of scientifically based medicine, which resulted in the formation of the Rockefeller Institute of Medical Research. Richard Brown suggests that in his transition from the ministry to directing the largest philanthropic and financial empire in the world, Frederick Gates "found himself converted from Baptism to capitalism and scientism...For Gates, the Rockefeller Institute for Medical Research was a 'theological seminary, presided over by the Rev. Simon Flexner, D. D.'" (1979: 125). Almost a hundred years later, in the conversion narrative of Bill Gates reading the *World Development Report 1993: Investing in Health*, there is a parallel process of clear acknowledgment of the inadequacies of the status quo prompting the formation of an endowment to the Bill and Melinda Gates Foundation (Moyers 2003).

103. This phrase is used by Osler to set the context for his remarks on "Medicine in the Nineteenth Century" as in "The century opened auspiciously, and those who were awake saw signs of the dawn. The spirit of Science was brooding over the waters" (Osler 1932: 220). After this phrase was cited by Ehrenreich and English, they suggest that: "Science was the transcendent force to which the doctors looked to lift medicine out of the mire of commercialism and gird it against foes. It was not only doctors who were eyeing science with professional self-interest. Science was well on its way to becoming a sacred national value, and any group which hoped to establish itself as the "experts" in a certain area would have to prove that they were rigorously scientific" (1978a: 69).
104. In 1902 a prominent medical writer warned physicians: "Do not allow yourself to be biased too quickly or too strongly in favor of new theories based on physiological, microscopical, chemical, or other experiments, especially when offered by the unbalances to establish their abstract conclusions or preconceived notions." This quotation was cited by (Ehrenreich and English 1978a: 89) from (Rothstein 1972: 266).
105. This is a concern that resurfaced at the World Medical Association's September 2003 general assembly in Helsinki. The number of medical schools has increased from around 1,300 in 1995 to nearly 2,000 in 2000. This 54% increase worries the president of the World Federation for Medical Education, Dr. Hans Karle, who argues, "The quality of education is not good enough. Some of these schools are badly needed, but many are being set up simply as businesses to attract students who cannot get into medical schools in their own countries." For-profit schools in the Caribbean accepted students who "have no chance of meeting the requirements of much more rigorous medical schools" in North America and the United Kingdom were noted to be of particular concern (Sullivan 2003).
106. Shryock noted the confluence of social trends with the advancements provided by "the German research drive and its achievement": "The implications of urbanization, increased wealth, and business efficiency were not lost on leading physicians. Competing within a free economy they observed that the scientific motive for educational reform coincided with their own professional ambitions.

They became increasingly aware that too many schools were turning out too many graduates to make practice profitable. This does not imply that educational and scientific appeals were mere hypocrisy. It simply means that these were so intertwined with economic interests as to make conclusions about the relative potency of each motivation almost impossible" (Shryock 1967: 57).

107. Shryock observed that some of the physicians already in practice who were directed to register their diplomas with the Illinois Board of Health "absolutely refused to do this—viewing the requirement as an entering wedge to state medicine" (1967: 53). Starr notes that some populists and liberals opposed medical licensure for a quite different reason: "Social Darwinists, following the English social theorist Herbert Spencer, though all such regulation unwise. "Very many of the poorer classes *are* injured by the druggists' prescriptions and quack medicines," Spencer willingly conceded. But there was nothing wrong in that; it was the penalty attached to ignorance. If the poor died of their own foolishness, the species would improve. The physicians, Spencer and others warned, meant to set themselves up as clergy" (Starr 1982: 105).
108. Lester King is another scholar who marks the Flexner Report as "a watershed" (1982: 297). King praises Flexner's advocacy of science for medical education but takes issue with Flexner's characterization of "good" and "bad" doctors. Flexner tends to dismiss all physicians before the 19<sup>th</sup> century as empirics, whose therapies had an automatic quality. King argues that a good physician, in any age, is one who goes beyond "reflex medicine" to "reflective medicine." Although theories change over time, good physicians think and evaluate carefully rather than clumping similar presentations together. King's anecdote illustrates the difference: "...a general practitioner who made a house call to a family whose six children, returning from a picnic, had all fallen ill with colic, vomiting, and other symptoms suggesting food poisoning. The overall story seemed simple enough, but the physician, after examining the children, said, "These five have food poisoning, but *this* one has appendicitis. That child went to the hospital and the diagnosis was confirmed by operation. This anecdote I consider the epitome of critical judgment and the application of scientific method to clinical practice" (King 1982:301).
109. John D. Rockefeller, Sr. (1839-1937) escaped military service during the Civil War by paying for a substitute to go in his stead. He started as a bookkeeper, then accumulated capital as a merchant, which he invested in oil refineries. He set up Standard Oil Company of Ohio in 1870 and drove competitors out of business by secret deals with railroads. By 1899 Standard Oil was a holding company controlling stock of many other companies and Rockefeller had moved into iron, copper, coal, shipping, and banking (Zinn 1980: 249-251). Kevin Phillips argues that instead of being "robber barons" the capitalists of the 1860s "simply got too much done" (2002: 39). Rockefeller's biographer notes that "he possessed a sense of calling in both religion and business, with Christianity and capitalism forming the twin pillars of his life" (Chernow 1998: 51). He "never wavered in his belief that his career was divinely favored and asserted bluntly: "God gave me my money" (Chernow 1998: 54). "John D. Rockefeller was the Protestant work ethic in its purest form, leading a life so consistent with Weber's classic essay that it reads like his spiritual biography" (Chernow 1998: 55).

110. Andrew Carnegie (1835-1919) was another robber baron who paid for a replacement to serve in his stead during the Civil War and then “used the war to take major steps up future fortune’s ladder” (Phillips 2002: 36). Carnegie started as a telegraph clerk, then secretary to the head of Pennsylvania Railroad, and subsequently became a millionaire selling railroad bonds on commission. He built a million-dollar steel plant using the new Bessemer method that he saw in London in 1872. By 1880 Carnegie was producing 10,000 tons of steel per month while foreign competition was discouraged by high tariffs set by Congress. By 1900 he was making \$40 million per year (Zinn 1980: 251). In his essay entitled “The Advantages of Poverty” he writes that “the fundamental idea of the gospel of wealth is that surplus wealth should be considered as a sacred trust to be administered by those into whose hands it falls, during their lives, for the good of the community” (Carnegie 1962: 55). In the universe that he inhabits: “millionaires can only grow amid general prosperity, and this very prosperity is largely promoted by their exertions. Their wealth is not made, as Mr. Hughes implies, at the expense of their fellow-countrymen. Millionaires make no money when compelled to pay low wages. Their profits accrue in periods when wages are high, and the higher the wages that have to be paid, the higher the revenues of the employer” (Carnegie 1962: 55). In his essay called “The Gospel of Wealth” he remarks that “it is a waste of time to criticize the inevitable” (Carnegie 1962: 15). His take on the “law of competition” is that “it is to this law that we owe our wonderful material development, which brings improved conditions in its train. But, whether the law be benign or not, we must say of it...It is here; we cannot evade it; no substitutes for it have been found; and while the law may be sometimes hard for the individual, it is best for the race, because it insures the survival of the fittest in every department” (Carnegie 1962: 16). This social Darwinist, at the top of the heap, is willing to “accept and welcome, therefore, as conditions to which we must accommodate ourselves, great inequality of environment...as being not only beneficial, but essential to the future progress of the race” (Carnegie 1962: 16-17).
111. Abraham Flexner was scathing about many of the schools that he visited. “As a matter of fact, many of the schools mentioned in the course of this recital are probably without redeeming features of any kind. Their general squalor consorts well with their clinical poverty: the class-rooms are bare, save for chairs, a desk, and an occasional blackboard; the windows streaked with dust and soot. In wretched amphitheaters students wait in vain for “professors,” tardy or absent, amusing the interval with ribald jest and song. The teaching is an unproductive rehearsal of textbook or quiz-compend: one encounters surgery taught without patient, instrument, model, or drawing” (1910: 124).
112. This passage from Flexner’s Report was prominently cited by a commissioned report on medical education in Canada (comprised by six physicians) to the Royal Commission on Health Services (MacFarlane et al. 1965: 21). They summarize: “...although it cannot be proved, it is suggested that the retarded reaction in Canada to some of the crucial implications of the Flexner Report is due to a variety of factors: economics; the “brain drain” to more advanced, more dynamic centres; and a complex of historical and cultural influences which have served on occasion to deflect attention from the areas of intellectual ferment” (MacFarlane et al. 1965: 24). While Flexner’s Report was influential in Canada, it is interesting to note reciprocally that Flexner used selected examples from Canada as a departure point for his report’s final exhortation to the United

States. "The high quality of instruction offered by McGill and Toronto to students who enter on less than a four-year high school education proves that our trouble in the United States has been at bottom not less one of low ideals than of low standards. Indeed, where ideals are low, there are no standards; and where ideals are high, the standard, even though low, is at any rate so definite that it furnishes a sure starting-point toward a clearly apprehended goal. The low standard school in the United States has had no such starting-point and no such goal" (1910: 326).

113. Most medical schools in Canada also started out as "proprietary enterprises" with university affiliation coming later (MacFarlane et al. 1965: 15). The eight medical schools that Flexner visited in Canada were: Manitoba Medical College (Winnipeg), Halifax Medical College, Medical College of Queen's University (Kingston, Ontario), Western University Medical Department (London, Ontario), University of Toronto Faculty of Medicine, McGill University Medical Faculty (Montreal), Laval University Medical Department (Montreal), Laval University Medical Department (Quebec). Flexner notes that these 8 schools served a population in Canada of 6,945,288. The number of physicians in Canada was 6,736 and ratio of physicians to population 1: 1,030 (1910: 321-325). Flexner listed data for each state separately. For example, California had 10 medical schools and a physician to population ratio of 1: 401 (1910: 188). New York had 11 medical schools plus 4 postgraduate schools with a 1: 617 ratio (1910: 265). This contrasts with the situation in the South. Alabama had 2 medical schools and a 1:924 ratio (1910: 185) while South Carolina had 1 medical school and a physician to population ratio of 1: 1,324 (1910: 300).
114. The population in Canada was 5,324,000 in 1901 and it more than doubled to 11,490,000 in 1941 (Judek 1964: 24). The population of the United States was also rapidly increasing but not quite at the same geometric rate. In 1900 the population of the United States was 75,994,575 and it increased to 131,669,275 by 1940 (Burner, Fox-Genovese, and Bernhard 1991: XXV).
115. The exact quotation is as follows: "But the physical well-being of the negro is not only of moment to the negro himself. Ten million of them live in close contact with sixty million whites. Not only does the negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors, precisely as the ignorant and unfortunate white contaminates him. Self-protection not less than humanity offers weighty counsel in this matter; self-interest seconds philanthropy. The negro must be educated not only for his sake, but for ours. He is, as far as human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion" (Flexner 1910: 180).
116. Flexner's argument that "self-interest seconds philanthropy" is one that has become increasingly familiar as globalization's flows increases anxiety about global migrations of people, goods, and microbes. Laurie Garrett's *The Coming Plague: Newly Emerging Diseases in a World Out of Balance* (1994) and *Betrayal of Trust: The Collapse of Global Public Health* (2000) are examples of this genre. People from non-dominant cultures have been and often are at increased risk for infection and disease due to poverty exacerbated by racism. Structural violence causes actual health disparities by race/ethnicity, class, and gender at the same



time as it perpetuates racist discrimination by stereotyping. Nancy Tomes narrates how African American and immigrant women were particular targets for the “gospel of germs” waged against “foreign microbes.” The Modern Health Crusade (founded in 1915) modeled its “war against tuberculosis” on “the Christians’ crusades against the infidels; as one young crusader observed in a prize-winning essay, ‘The germs are the Turks’” (1998: 124).

117. Paul Starr notes “A 1920 study by the biostatistician Raymond Pearl showed the distribution of physicians by region in the United States was closely related with per capita income. Doctors, Pearl concluded, behaved the way all “sensible people” might be expected to. “They do business where business is good and avoid places where it is bad” (Starr 1982: 125).
118. Flexner’s Report was attacked for not being of the scientific standard that was being imposed. “Flexner’s haste in inspecting in a period of three months sixty-nine medical schools in twenty-two states in not more than seventy-eight working days raises serious questions” (Burrow 1977: 47). Hudson argues that it is a myth to contend that the visits were too brief for accuracy given that a modern accreditation visit may only require a few days. His example is the 1986 Kansas University Medical School site visit by the Liaison Committee on Medical Education took “only a bit more three days” for a full-time faculty of 560 and an annual operating budget of \$170 million (1992: 16-17).
119. The Royal Commission on Health Services puts the point more delicately in their discussion of historical sources used as background to their consideration of medical education in Canada when they write particular references “have been helpful although agreement between them has been often incomplete” (MacFarlane et al. 1965: 12).
120. The discussion of the Bill and Melinda Gates Foundation in Chapter Two is an example of cognitive dissonance.
121. “The centre cannot hold” comes from the first part of “The Second Coming” by W. B. Yeats (1865-1939):
 

Things fall apart; the centre cannot hold;  
 Mere anarchy is loosed upon the world,  
 The blood-dimmed tide is loosed, and everywhere  
 The ceremony of innocence is drowned;  
 The best lack all convictions, while the worst  
 Are full of passionate intensity.
122. Applicants were lured with extravagant advertising (one school offered any graduate in attendance three years a trip to Europe), accepted with only a bit of elementary school education or with forged documents, and taught by professors with widely variable competence and dedication but the wherewithal to purchase an academic chair. In some schools being current with tuition payments, if not class attendance, assured a degree. A more cynical approach, at least toward the students, was, as one dean admitted, to carry “men easily from class to class, but plucked them in the last year” (Flexner 1910: 37). This allowed the collection of three years’ fees while avoiding low scores on the state board examinations.

123. In addition to the fee-for-service kind of relationship between students and faculty (with the emphasis more on fee than service as described in the previous footnote), another marker of medical education as a product line, was the formation of medical schools as stock companies. The Birmingham Medical College, organized in 1894, was an example of such a stock company, paying annual dividends of 6 per cent (Flexner 1910: 185).
124. Just as the volume and complexity of William Osler's work predisposed his rhetoric to be used on conflicting sides of many issues, Rudolf Virchow's example in creating the first pathological institute in 1856 was utilized by Flexner to shore up his argument for the importance of the laboratory branches of medical education (Flexner 1910: 65-66). Flexner argues more broadly of the physician that "...scientific progress has greatly modified his ethical responsibility. His relation was formerly to his patient—at most to his patient's family; and it was altogether remedial. The patient had something the matter with him; the doctor was called in to cure it. Payment of a fee ended the transaction. But the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and moral well-being. It goes without saying that this type of doctor is first of all an educated man" (1910: 26).
125. Overarching interests of the corporate classes are to have workers healthy enough to be productive and consumers solvent enough to purchase goods and services. More specifically, the philanthropic enterprises of the Rockefeller Family might also be understood in terms of social control. The educational institutions founded by Rockefeller, Carnegie, Johns Hopkins, Cornelius Vanderbilt, Ezra Cornell, James Duke, and Leland Stanford "did not encourage dissent; they trained the middlemen in the American system—the teachers, doctors, lawyers, administrators, engineers, technicians, politicians—those who would be paid to keep the system going, to be loyal buffers against trouble" (Zinn 1980: 257). Even so, monopolistic practices of the Standard Oil Company caused resentment. Rockefeller Junior's denial of the Ludlow Massacre of 1914 (where eleven children and two women were burned and thirteen people killed by gunfire during a strike against the Colorado Fuel and Iron Company) provoked anger. Helen Keller, who had received assistance from Rockefeller, told the press "Mr. Rockefeller is the monster of capitalism. He gives charity and in the same breath he permits the helpless workmen, their wives and children to be shot down" (Chernow 1998: 579). Although tunnel carpal syndrome and loss of stock options are not equivalent dangers to National Guard companies attacking tents with machine guns (Zinn 1980: 347), Bill Gates's company also has need of softening public relations. Microsoft faces legal challenges for antitrust violations just as did Standard Oil. Microsoft also has its own labor troubles. "Temporary" employees who had been with Microsoft for years but were paid through temporary employee agencies so that they would not have to be paid benefits filed the "permatemps" lawsuit in 1992. Microsoft announced a settlement for \$97 million (of which \$27 million goes to the lawyers) in December 2000 (Gillespie 2002).
126. (Centers for Medicare and Medicaid Services 2002: 27)

127. United States Department of Health and Human Services website, accessed August 8, 2003 <http://www.hhs.gov>
- United States Department of Health and Human Services website, accessed August 8, 2003 <http://www.hhs.gov>
128. It is actually a bit difficult to trace spending on science. Daniel Greenberg explains some of the difficulty as follows. "The official compilations from which these numbers are taken are booby-trapped with footnotes declaring definitional shifts from past series of numbers, warnings of noncomparability, ex-post facto amendments to previously declared final data, cautions against misinterpretation, and other mystifications of the statistics trade, including confessions of errant billions" (2001: 78).
129. "Lottery" is perhaps not too strong a metaphor for 44,000 annual applications for research and training grants necessitating a tiered review process complete with multiple decision trees. For examples please see <http://grants1.nih.gov/grants/peer/peer.htm> This 44,000 is a huge increase from the 13,304 proposals received in 1977 to the 19,205 proposals received in 1988 at NIH (Greenberg 2001: 102). Greenberg cites an Office of Technology Assessment report entitled *Proposal Pressure in the 1980s: An Indicator of Stress on the Federal Research System* as follows: "A kind of lottery mentality appears to have taken hold in the 1980s: the more grant proposals submitted, the greater the probability that one would be funded. As competition grows, resources for rewarding quality seem to shrink. In addition, some researchers, both those who often succeed in winning Federal funds and those who do not, argue that agency decisions tend to grow conservative and the chief attribute of basic research—risk taking—declines" (Greenberg 2001: 102).
130. In 1980 the top university recipients of federal research funds were Johns Hopkins, Massachusetts Institute of Technology, Stanford, the University of Washington, the University of California at San Diego, the University of California at Los Angeles, Harvard, Columbia, the University of Wisconsin at Madison, and Cornell University. In 1995, Johns Hopkins, University of Washington, Wisconsin, Massachusetts Institute of Technology, and University of California at San Diego remained in the top ten, while the others previously listed remained in the top twenty (Greenberg 2001: 38).
131. A similar dynamic might be seen in federal financial support to institutions of higher learning for low-income students. Ivy league schools (such as Harvard and Yale with endowments of more than \$10 billion each and Princeton with an endowment of 8.7 billion) received 5 to 20 times the median amount of grant money to look after their poor students. During the 2000-2001 academic year, for every Pell dollar one student received (with students being eligible for up to \$4,000 each), the median college received an extra 7 cents. In contrast, Harvard received 98 cents, Massachusetts Institute of Technology received \$1.09, and Princeton received \$1.42. *The New York Times* explains: "As for the origins of the disparities, most veterans of university finance agree that they date back at least to the 1970's, when regional panels of educational experts, not formulas, decided how much colleges would receive. Because each university had to make its own case for the money, those with long histories and a certain financial savoir-faire tended to do particularly well. In fact, the panels were sometimes composed of

their peers. "If a school was politically savvy and well connected enough, they would end up with lion's share of the funds," said Ken Redd, research director of the financial aid officers association" (Winter 2003).

132. Greenberg cites a 1999 article entitled "Reassessing an NSF Program for Research Have-Nots" in the *Chronicle of Higher Education*: "It always seemed strange to us, when NSF talked about funding the very best research, that there was this program," said Allen J. Sinisgall, associate provost for research at Princeton University. "This is kind of an unnecessary propping up of individual institutions in regional areas" (2001: 39).
133. This view is articulated by Robert Tenery, MD, Chair of the Council on Ethical and Judicial Affairs, AMA: "...this country is where it is today, not because of how poorly, but because of how well the healthcare system has performed. Led by the physician community, hospitals, teaching and research institutions, and drug companies all joined together to develop the highest level of health care in the history of mankind" (Tenery 1999: 252).
134. Bliss notes that "As a Christian philanthropist, Howard Kelley had given away about three times his Johns Hopkins income, and hardly considered himself contaminated by greed" (1999: 383). This comment should be considered in the context of the following passage about Kelley in Osler's writings on the "Inner Life" of Hopkins: "(Kelley) had probably the largest professional income among surgeons in the United States. He charged very large fees, \$10,000 to \$12,000 for some of his more important operations. He seemed conscienceless in the matter, & yet men have told me that after conversation with him they were glad to get away without making an assignment of their estates. He was exceedingly liberal and gave with great freedom both to the hospital, to his assistants & to general charities" (Bliss 1999: 278).
135. George Soros, a beneficiary of what John Maynard Keynes called the "casino economy" (Barnet and Cavanagh 1994: 17), is a subsequent critic of the global capitalist system who takes credit for coining the term "market fundamentalism:" "Financial markets are inherently unstable and there are social needs that cannot be met by giving market forces free rein. Unfortunately these defects are not recognized. Instead there is a widespread belief that markets are self-correcting and a global economy can flourish without any need for a global society. It is claimed that the common interest is best served by allowing everyone to look out for his or her interests and that attempts to protect the common interest by collective decision making distort the market mechanism. This idea was called laissez faire in the nineteenth century but it may not be such a good name today because it is a French word and most of the people who believe in the magic of the marketplace do not speak French. I have found a better name for it: market fundamentalism. It is market fundamentalism that has rendered the global capitalist system unsound and unsustainable...It is market fundamentalism that has put financial capital into the driver's seat" (Soros 1998: xx).
136. Karl Polanyi (1886-1964). Polanyi's work has recently attracted interest by scholars critical of globalization. *The Great Transformation: The Political and Economic Origins of Our Time* was first published in 1944 and was reissued in (2001) with a foreword by Joseph Stiglitz. Linda McQuaig takes Karl Polanyi's

work as her point of departure in *All You Can Eat: Greed, Lust and the New Capitalism* (2001).

137. Polanyi explains: "The poorhouse was transformed from a refuge of the destitute into an abode of shame and mental torture to which even hunger and misery were preferable. Starvation or work was the alternative left to the poor. Thus was a competitive national market for labor created. Within a decade, the Bank Act (184) established the principle of the gold standard; the making of money was removed from the hands of the government regardless of the effect upon the level of employment. Simultaneously, reform of land laws mobilized the land, and repeal of the Corn Laws (1846) created a world pool of grain, thereby making the unprotected Continental peasant-farmer subject to the whims of the market. Thus were established the three tenets of economic liberalism, the principle on which market economy was organized: that labor should find its price on the market; that money should be supplied by a self-adjusting mechanism; that commodities should be free to flow from country to country irrespective of the consequences—in brief, a labor market, the gold standard, and free trade. A self-inflamatory process was induced, as a result of which the formerly harmless market pattern expanded into a sociological enormity" (1968: 67-68). It is interesting to note Polanyi's metaphor of "self-inflamatory process" underlines the importance of health as a trope of political economy. Polanyi's "sociological enormity" has only increased over time as critics of welfare reform (Schram 1995), monetarism and the "natural rate of unemployment" (McQuaig 1998), and free trade (Brenner et al. 2000) (Sanger 2001) persuasively argue.
138. The true scope of such a step can be gauged if we remember that labor is only another name for man, and land for nature. The commodity fiction handed over the fate of man and nature to the play of an automaton running in its own grooves and governed by its own laws" (Polanyi 1968: 62).
139. (Wills 1987: 433).
140. Cited from the Franklin Delano Roosevelt Memorial, Washington, D.C.: "I pledge you, I pledge myself, to a New Deal for the American People." Acceptance of Nomination for President, Chicago, Illinois July 2, 1932
141. First inaugural address of Franklin Delano Roosevelt took place on March 4, 1933. Available at: <http://www.bartleby.com/124/index.html>, accessed September 15, 2003
142. I think this is a fair statement even while recognizing that the Banking Act was drafted in collaboration with the money changers in the big banks (Burner, Fox-Genovese, and Bernhard 1991: 781) and acknowledging critiques by scholars who underscore some of the New Deal's important limitations. Howard Zinn, for example, points out that the Social Security Act gave retirement benefits, unemployment benefits, and matched state funds for dependent children and mothers but it excluded domestic workers, farmers, old people, and offered no health insurance (1980: 394). Zinn points out that African Americans were "psychologically encouraged" by New Deal programs but "most blacks were ignored by New Deal programs. As tenant farmers, as farm laborers, as migrants, as domestic workers, they didn't qualify for unemployment insurance, minimum wages, social security, or farm subsidies (1980: 394). Some of the important New

Deal initiatives included: Emergency Banking Act, Agricultural Adjustment Act, Tennessee Valley Authority, Civilian Conservation Corps, National Industrial Recovery Act, National Labor Relations Act, Social Security Act, and the Works Progress Administration (Burner, Fox-Genovese, and Bernhard 1991).

143. Second inaugural address of Franklin Delano Roosevelt took place on January 20, 1937. Available at: <http://www.bartleby.com/124/index.html>, accessed September 15, 2003
144. Deane Neubauer has noted that recognition of the state as a legitimate agent of income redistribution was novel because it rejected the premise that individuals were ultimately responsible for their own welfare. Welfare premises were accepted by conservative leaders (Disraeli in England and Bismarck in Germany) "on the pragmatic grounds that to do so was ultimately less costly than refusing to recognize the need to ameliorate some of the worst excesses of industrial capital and thereby add fuel to the fire of those seeking to dismantle the capitalist underpinnings of the liberal state on largely humanitarian grounds" (1999: 5).
145. Remarks by Lydon B. Johnson at the University of Michigan, May 22, 1964.
146. First inaugural address of Ronald Reagan took place on January 20, 1981: <http://www.bartleby.com/124/pres61.html>, Accessed September 15, 2003
147. "In this present crisis, government is not the solution to our problem; government is the problem" is the exact quotation as archived within the first inaugural address found at the Reagan Library, at <http://www.reagan.utexas.edu/resource/speeches/1981/12081a.htm>. Although this meaning is clear in this version of the address cited within the text of the dissertation, "government is the problem" is not found in the same passage at: <http://www.bartleby.com/124/pres61.html>.
148. This quotation is from an interview that Margaret Thatcher gave to *Women's Own* magazine, October 3, 1987. Under a title "Epitaph for the eighties: 'no society'" this citation may be found at <http://briandeer.com/social/thatcher-society.htm>, accessed September 17, 2003.
149. An excellent companion to Gary Willis's *Reagan's America* is his volume entitled *John Wayne's America* (1997) which elucidates why "cowboy economics" is such an fitting description for a nation rooted in mythologies of frontier. The extent to which cowboy mythology colonized the sensibilities of Ronald Reagan might be suggested by a story he told to veterans at the Capital Hill Hilton Hotel Inaugural Ball on January 20, 1981: "I've been told that you are honoring here tonight, as well any of us should, our Congressional Medal of Honor winners. And when I think of them, I remember a story I read once, and it was actually a novel, written by James Warner Bella, who used to write those great cavalry-Indian pictures that John Ford and John Wayne would do. He was called the Kipling of America for writing of that great era in American history. But I remembered in this one story he had troops, a cavalry detachment out, a war party, and so forth. And the commanding officer fell mortally wounded, and he called the next in command over, who was to take over. And the lines I've never forgotten. He said to him as he was dying, "There may be only one time, one moment in your life when you will be called upon to do the nasty thing that has

to be done, when you are the only one that can serve your country in that moment." He said, "Do it or the taste will be forever ashes in your mouth." <http://www.reagan.utexas.edu/resource/speeches/1981/12081g.htm>

150. The medicalizing term of "Enronitis" is not uncommon. Transparency International (2003: 80) uses it as a subtitle for a case study within its *Global Corruption Report 2003*. *Nursing Homes* also used it as a title on "social responsibility" in the nursing home industry (Peck 2002). A similar metaphor is used in an article entitled "Infectious Greed" in the *Australian CPA* journal that used Enron as a prototypical example (Nofsinger and Kim 2003).
151. David Stockman's account as a self described "radical ideologue" (Stockman 1986: 14), in *The Triumph of Politics: How The Reagan Revolution Failed*, describes his disappointment with the incompleteness of the Reagan Revolution which "required a frontal assault on the American welfare state" (1986: 8). His metaphors of being a "born again capitalist" (Stockman 1986: 31) trying to "sell that gospel" (1986: 54) included a late realization that "maybe we were not all crusaders on the road to Jerusalem" (Stockman 1986: 243). Stockman describe Reagan as the "Great Communicator" and "the most compelling head of state since Roosevelt" (1986: 79), who was "misled by a crew of overzealous—and ultimately incompetent—advisers" (1986: 341).
152. *The Wall Street Journal* described the collapse "like a house of cards" as being attributable to "aggressive accounting to hide massive debt and inflate the bottom line—enriching top executives in the process" (Executives on Trial: Scandal Scorecard 2003). The average amount of compensation for the senior managers was \$5 million. Former chairperson, Kenneth Lay, received \$150 million. Transparency International (2003) also points out that Enron contributed \$5.95 million in soft money (74% going to the Republicans) including having the distinction of being George Bush's largest campaign contributor. Congress opened hearings on whether Enron had received preferential treatment by the Bush administration but had to file a lawsuit to demand records from the administration's energy task force. An additional note is that thousands of people who were not directly involved in Enron still lost retirement income as Enron was a member of the Standard and Poors 500 Index until November 29, 2001. By the time Enron was dropped from the Standard and Poors 500 Index it had lost over 99% of its market value. Alliance Capital Management, the investment manager for the Florida Retirement System, was still purchasing Enron stock even after the Securities and Exchange Commission announced its investigation into Enron in October 2001. Estimates of Florida State Retirement System's losses due to Enron range from \$281 to \$321 million (Sridharan, Dickes, and Caines 2002).
153. Enron hired lobbyists by the bushful. It doled out tens of thousands of dollars in campaign contributions to Californian politicians. Lay and Skilling made stump speeches touting deregulation's benefits. In one appearance before the California Public Utilities Commission (CPUC), Skilling claimed that the state would save \$8.9 billion a year: 'Let me tell you what you can buy every year,' he said. 'You can triple the number of police in Los Angeles, San Francisco, Oakland, and San Diego, and you could double the number of teachers' (McLean and Elkind 2003: 265).

154. "Megawatt laundering" included a scheme to export power out of California and then reimport it for a higher price after helping to create a shortage. Enron named some of their ploys to maximize profit by "gaming" the system as "Death Star," "Get Shorty," "Fat Boy," and "Ricochet." (McLean and Elkind 2003: 264-283). Energy traders at Enron characterized their culture as follows: "The attitude was, 'play by your own rules,' says a former trader. "We all did it. We talked about it openly. It was the school yard we lived in. The energy markets were new, immature, unsupervised. We took pride in getting around the rules. *It was a game*" (McLean and Elkind 2003: 275).
155. The West Coast power division of Enron booked \$460 million in profits in 2000 and other West Coast gas traders made \$870 million for that year. According to a Moody's presentation, the entire North American trading desk for Enron made \$2.2 billion in 2000 (McLean and Elkind 2003: 282). Journalists for *Fortune*, McLean and Elkind, who interviewed Enron traders, write: "'If they're going to put in place such a stupid system, it makes sense to try to game it,' says one former senior Enron executive, in a comment that perfectly summed up the prevailing attitude inside the company. That their actions might cause turmoil and hardship, that they might affect businesses up and down the state, well, from the point of view of the Enron traders, that was California's problem, not theirs. 'It was the traders' job to make money, not to benefit the people of California,' says another former Enron executive" (2003: 267-268).
156. This crisis in California was characterized by rolling blackouts (the first since World War II in California), and huge price increases. In June 2000, the total wholesale cost of electricity was more than \$3.6 billion, approximately half of what power cost for all of 1999 (McLean and Elkind 2003: 272).
157. Prosecutors indicted the entire firm on criminal charges. Arthur Andersen is appealing its criminal conviction but it ceased to exist as a U.S. accounting firm in the fall of 2002 as it surrendered all of its state licenses. From 28,000 employees the company went to a shell of 250 employees in the United States (Executives on Trial: Scandal Scorecard 2003).
158. Jeff Skilling, former President of Enron, described Enron with evangelical fervor: "'We were doing something special. *Magical*.' The money wasn't what really mattered to him, insisted Skilling, who had banked \$70 million from Enron stock. 'It wasn't a job—it was a mission,' he liked to say. 'We were changing the world. We were doing God's work'" (McLean and Elkind 2003: xxv). Mixed with this religious intensity, the trading culture of Enron seems to be dependent on large doses of testosterone. An admired head trader who became president after Skilling resigned, Greg Whalley was described by "the traders (who) worshipped him. 'Whalley is a screaming stud,' they'd say" (McLean and Elkind 2003: 214). The metaphors for this competitive environment are telling: "If you showed any weakness, the antibodies would attack," says a former trader. "Life at Enron," says another, "was the purest form of balls-out guerilla warfare" (McLean and Elkind 2003: 217). These elements combine for a particular Enron ethos: "One thing the traders all loved about Enron was the sense they had of operating in the purest environment that had ever been created in corporate America. By pure, they meant that the trading floor operated strictly by the dictates of the free market...they believed that the market was the ultimate judge



of their work and their worth. The market created a true meritocracy: you either made money because you made good trading decisions or you lost money because you made bad ones. Enron traders didn't concern themselves with ethics or morality apart from the unyielding judgment of the markets. Maximizing profit was not inconsistent with doing good, they believed, but an inherent part of it, and the judge of good and bad was the immediate consequence of a split-second trade. The highest compliment a trader could pay a colleague was to call him intellectually pure. The worst insult was to accuse someone of making a deal that wasn't economic" (McLean and Elkind 2003: 216).

159. An example of what some would term "misleading accounting" has also been described as "looted the company on a massive scale" (Executives on Trial: Scandal Scorecard 2003). The founder of this company, John Rigas, his two sons and three executives were indicted on federal fraud charges and the Securities and Exchange Commission also filed civil charges. The government is seeking \$2.5 billion in "allegedly illegal proceeds" from the Rigas family (Executives on Trial: Scandal Scorecard 2003).
160. In April 2002 Citigroup agreed to pay \$400 million to settle government charges related to issuing fraudulent research reports and engaging in "IPO spinning." (This involves allocating shares of initial public offerings to executives of other companies to win business.) A "star analyst," Jack Grubman agreed to be banned for life from the securities industry and pay a \$15 million fine "without admitting or denying" any wrong doing. Citigroup agreed to pay \$145 million to settle state and federal investigations into its dealings with Enron and Dynegy (Executives on Trial: Scandal Scorecard 2003).
161. Assistant U.S. Attorney Michael Schacter charged that Waksal "told numerous, separate and distinct set of lies" surrounding his family's sale of ImClone stock. Schacter further accused Waksal of violating "a sacred trust with his shareholders" and said of his actions: "It runs the risk of sending the message to investors that the game is rigged" (Associated Press 2003d). Rigging the system by insider trading is a concern that would be reinforced by following investigations of Tyco International (Transparency International 2003) and Goldman Sachs. A former senior economist at Goldman Sachs, John Youngdahl, plead guilty to criminal charges related to the purchase of \$318 million of 30-year bonds and bond futures just ahead of the Treasury Department's announcement that it was ending the sale of 30-year bonds. Goldman Sachs reached a settlement with the Securities and Exchange Commission "without admitting or denying the allegations" to pay back the \$3.8 million in profits, \$500,000 in interest, and a \$5 million penalty (Fuerbringer 2003).
162. One example is that Gary Pilgrim and Harold Baxter, founders of PBHG Funds, allowed two investors to trade billions of dollars in and out of their mutual funds while discouraging other investors from such trading. This generated millions of dollars of profit for the two investors at the expense of the other funds' shareholders. While some people wondered why Pilgrim and Baxter would risk their multibillion-dollar operation with fraud charges, A. Michael Lipper, who "has long been involved with tracking funds" said, "What this says is they did not perceive it to be a problem or they didn't think they would get caught" (Abelson and Atlas 2003). Other firms that are under review for suspect trading

practices are American Express, Bank of America, Charles Schwab, Legg Mason, Putnam Investments, Strong Mutual Funds, and Wachovia (Thomas 2003).

163. Accounts of corruption among politicians are legion. Two examples from Transparency International's regional report on North America are patronage in the awarding of federal contracts to supporters of the Liberal government of Jean Chrétien and the eight year federal prison term and expulsion from Congress of Representative Alfonso Gagliano for bribery and racketeering (2003: 83). A more intriguing situation is what critics call "a creative maneuver" to get around soft money campaign funding restrictions by Republican leaders. Tom Delay is inviting potential donors to give as much as \$500,000 to spend time with Delay at the 2004 Republican convention in New York City with part of the money going to help neglected and abused children. The president of Democracy 21, Fred Wertheimer, said "They are using the idea of helping children as a blatant cover for financing activities in connection with a convention with huge unlimited, undisclosed, unregulated contributions." Donors will obtain tax breaks while the campaign contributions are shielded from oversight. An adviser to Delay, Craig Richardson, explains that the goal is to give 75% of the money to children's charities. He said "We are using the opportunity to throw parties, which happen anyway, but to give money back to abused and neglected children." Dr. Bill Frist is also reportedly in the early planning stages of tying charity for five AIDS organizations with the Republican convention. Observers suggest that this is an "ethical gray area" between election law and tax law. Larry Noble, executive director for the Center for Responsive Politics, commented: "The event itself is being put on in a political atmosphere. It is clearly playing off DeLay's political leadership, and playing to people who find it in their political interest to be at the Republican convention. In that sense it is political. But does it make it a political activity on behalf of the charity?" (Slackman 2003).
164. The entrepreneurial activities of civil servants in Illinois in June 2002 resulted in indictments of 50 state employees. The charges were demanding bribes in order to obtain commercial drivers' licenses, kickbacks on contracts and leases, and the diversion of state funds to political activities (Transparency International 2003: 83).
165. Performance enhancing drugs such as difficult to detect "designer steroids" are said to have "undermined, and perhaps even destroyed, the reliability of sports as fair play" (Longman 2003b). From 5 to 7 percent of drug tests collected in the 2002 season by Major League Baseball tested positive for steroids (Longman 2003b). The appeal of performance enhancing drugs was outlined by this sports fan: "If you asked the average male if they would take a steroid that would make them idolized by millions as a professional athlete, that would allow them to make millions of dollars but would shorten their lives by 10 years, the vast majority would say, "Yes" (Longman 2003b). Craig Masback, chief executive of USA Track and Field, maintains that the majority of athletes do not use drugs but it still "a national problem" because at the elite level of competition "there is just no way of knowing" (Longman 2003b). While some worry about the erosion of integrity and trust in sports described as "crises of legitimacy," others argue that "as long as our players are bigger and faster than your players, we don't care. Or we say 'Isn't that horrible?' while were getting our next prescription for Rogaine or calling the doctor to order more Viagra" (Longman 2003b). One commentator, Diane Nyad, predicts that performance

enhancing drugs are quickly becoming normalized: "We will one day not long from now see athletes advertising THG on their headbands as we now see Gatorade" (Longman 2003b). A University of Michigan survey found that 4% of high school seniors and 3% of students in eighth grade had used steroids in 2002 (Longman 2003a). Longman (2003a) reports that other surveys of high school students range from 3 to 11% steroid use. With estimates of 500,000 to 1 million high school students using steroids, side effects can include depression with risk of suicide, infertility, hypertension, liver damage, and prostate cancer (Longman 2003a).

166. "Unrelenting pressure to achieve" is purportedly fueling "epidemic cheating" at Staples High School in Westport, Connecticut. High school junior, Alicia Berenyi, describes the annual list of where seniors are headed for school. "If it's not Harvard, Yale or Princeton, you get that look," she said, less from fellow students than from parents or other adults. "It's almost like they think it's proof of what kind of person you are." Senior Aaron Eisman explains that "Expectations are set here, externally and internally. In Westport, getting a B is like getting an F. So if you don't feel you can achieve it on your own, you find another way" (Gross 2003). As in an earlier footnote with the terms Eronitis and "infectious greed," academic cheating is given the medicalized descriptor of "contagious" in this *New York Times* account. Gross cites two studies to provide "ample statistical evidence of the explosion of cheating in high schools." The first is by Michael Josephson who found that 74% of 10,000 high school students surveyed in 2002 had cheated on a test in the previous year compared with 61% ten years earlier. The second study by Donald McCabe traced an increase from 25% in 1963 to 50% in 1993 to 75% in 2001 of students had cheated on at least one test among 4,500 high school students surveyed. Josephson said that high schools "generally turned a blind eye to cheating." "I don't think this is a generation of moral mutants," he said. "What's changed is parenting. If you catch their kids cheating they threaten a lawsuit" (Gross 2003).
167. Writing in the holy text of the *Wall Street Journal* the fruit of The Market itself precludes any need for apologies: "When the government fails in its most basic functions—say, protecting our citizens from foreign enemies—no one at the FBI or CIA loses his job, we all gather around to salute the flag and Washington gives us yet another bureaucracy. But if business stumbles—say a minor recession and the collapse of stock values many had thought inflated—businessmen are hauled into court and the air is full of proposals for 'reform.' It's no use complaining about this little irony, I suppose. Indeed, scrutiny, competition and the clear bottom-line test of success or failure are the tools business use to improve its performance. Over time that performance scarcely demands apology. As Henry Paulson of Goldman Sachs pointed out in his widely noted speech last week, since June of 1981 the economy has almost doubled and created 40 million jobs, while the stock market is up 21/2 times" (Bartley 2002). It is a testimony to Bartley's faith that he can explicate this "little irony" without mentioning that stock inflation and its subsequent collapse were predicated by insider trading and fraudulent accounting.
168. At Tufts University on March 27, 2000, John Kenneth Galbraith also helpfully explained "trickle-down theory" as "if you feed the horse enough oats, some will pass through to the road for the sparrows" (Conniff 2002: 163).

169. John Coffee is a professor of securities law at Columbia University. He described Enron as “the private sector’s Watergate” (Wessel 2002).
170. Some commentators term the convergence of neoliberal free market doctrine and traditional conservative views on limited government as “neo-conservative” (Shakow and Irwin 2000: 437).
171. Political science professor, Kate Zhou, for example, made the following comments in an interview with the *Honolulu Weekly*: “I have a favorite expression, “Trade with us or trade places,” said Zhou ever smiling. “If you do not want to trade with us then you try to live in our shoes.” It’s a sentiment that she conveys to people against globalization. “Of course, there are bad things that come with globalization. But it’s not right to tell a poor Chinese person that he cannot have air conditioning, while we sit here with air conditioning. If it causes more pollution, then so be it. We will all die together then. It’s not fair for one people to have modern conveniences while others must continue to suffer,” Zhou said. “This is the voice of the poor. Everywhere I go in China, the poor people tell me that they are ready to trade, ready to open up to the rest of the world” (Wang 2003).
172. George Ritzer traces the “frontiers of McDonaldization” (2000: 146) into the realms of reproductive technology, the death industry, and medical care with “Docs-in-a box” clinics staffed by “McDoctors” (2000: 51).
173. “Predatory capital” is an image borrowed from Michael Shapiro, graduate seminar, Department of Political Science, University of Hawaii at Manoa, Spring 2003.
174. It is estimated that while in confinement in the stockade or on the march westward along the Trail of Tears, 4,000 Cherokees died in 1838. Others who were forcibly removed from their homes or died resisting include the Creeks, Choctaws, Chickasaw, and Seminole peoples. Howard Zinn describes President Andrew Jackson as a “land speculator, merchant, slave trader, and the most aggressive enemy of the Indians in early American history” (1980: 125). As treaty commissioner with the Creeks, Jackson’s 1814 treaty started a dangerous trend. “It granted Indians individual ownership of land, thus splitting Indian from Indian, breaking up communal landholding, bribing some with land, leaving others out—introducing the competition and conniving that marked the spirit of Western capitalism.” Jackson informed the Creeks that “they had better cede the lands or be wiped out.” With justification, Zinn equates “land grabs” with “treaties” (1980: 127).
175. On December 3<sup>rd</sup>, 1984, 40 tons of poisons escaped from the Union Carbide pesticide plant in Bhopal, India. The Indian government claims that 1,754 died and 200,000 were injured. Non-governmental sources estimate that almost 10,000 died and 300,000 were injured. Timothy Holtz notes that Union Carbide used public relation campaigns to shift attention from their responsibility even as their profits soared while those affected have not received sufficient compensation. In keeping with the non-innocence of health theme in chapter two, it is pertinent to note here the comments of a Georgia Tech physician to the *New York Times*: “Of those killed, half would not have been alive today if it weren’t for that plant and

the modern health standards made possible by the wide use of pesticides" (Holtz 2000: 245).

176. Thomas Friedman, *New York Times* columnist and author of *The Lexus and the Olive Tree* provides many examples such as: "So there I was: in the morning listening to Bill Gates telling me that the Fast World was about to get even faster and in the afternoon listening to Adebbe telling me he wanted to hop on but could someone just slow it down a bit. I wish we could slow this globalization train down, I told Adebbe, but there's no one at the controls (2000: 343).
177. Additional information about Andrew Carnegie and this point may be found in Chapter 3.
178. Examples include: male stowaway falling to his death out of jet's landing gear (Baker 2001); 86 Somali people who drowned after being forced at gunpoint into the sea (CBC 2001); 14 Mexican people who died after being abandoned in the Arizona desert (Associated Press 2001), and 18 people who suffocated in a trailer truck in Texas (Associated Press 2003e).
179. To take but one example, there are reported to be about 325,000 L-1 visa holders in the United States. This visa category was designed to allow companies to transfer employees from foreign branches or subsidiaries to the United States but is now used routinely by companies to bring highly skilled employees into the United States and contract them out. Unlike the H-1B visas, the L-1 visa does not require employers to pay workers prevailing wages. Technology workers have complained that they have lost their jobs to people with L-1 visas and that wages have been driven down. Anecdotal reports are that some have been asked to take a \$30,000 pay cut in order to keep their jobs (Hafner and Preysman 2003).
180. A comprehensive study of the "geography of blame" may be found in Paul Farmer's study of Haiti and accusations about HIV disease (Farmer 1992). During the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, "urban legends" spread across North America alleging that commercial enterprises and people in Chinatown were spreading SARS (accessed September 13, 2003 <http://urbanlegends.about.com/library/bl-sars-restaurants.htm>). Businesses and restaurants in Honolulu's Chinatown estimated that they were experiencing losses in sales from 30% to 75% during the height of public concern (Hao 2003).
181. For example see (Institute of Medicine 1997; Kassalow 2001)
182. For samples of literature on food safety see: (Rhodes 1997) (General Accounting Office 2001a) (Centers for Disease Control and Prevention 1998) <http://www.cdc.gov/ncidod/emergplan/planrequest.htm>
183. A report by the General Accounting Office tracks the impact on health and social services by migration from Micronesian nations to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. The U.S. areas have collectively reported at least \$371 million in costs to local governments associated with serving the needs of migrants from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau for 1986-2000. Departing limited economic opportunities at home, more than 50% of people who have migrated are living in poverty and are stuck in low wage employment.

(General Accounting Office 2001b) The Hawaii State Primary Care Association notes that more than 27,300 uninsured residents of Hawaii depend on the state's ten community health centers for health care. Uninsured patients in Hawaii have increased 67 percent since 1997 (Altonn 2003).

184. An uninsured Mayan farm worker, Luis Alberto Jimenez, who suffered brain damage in a motor vehicle accident was "clandestinely deported" by a hospital in Stuart, Florida to Guatemala after expending more than one million dollars for his medical care (Associated Press 2003c).
185. The *Wall Street Journal* has long been a close follower of the AIDS pandemic, antiretroviral product lines, and scientific advances that might be investment opportunities. The extent to which a health care system in an industrialized country can be overwhelmed was illustrated by the SARS outbreak in Toronto in 2003.
186. Prime Minister Blair appointed a pioneering heart surgeon, Sir Magdi Yacoub, as an "NHS Ambassador to scour the world for 450 foreign consultants to fill empty hospital posts." Heart and lung surgeons, psychiatrists, and radiologists were of particular interest and New Zealand and Canada were mentioned as far afield places that would be searched (Blair Appoints NHS Ambassador to Woo Foreign Surgeons 2002). More than 50% of the physicians practicing in the province of Saskatchewan are international medical graduates. The Kirby Commission notes this figure and opines that as many countries face similar shortages "there does not seem to make sense for all developed countries to poach endlessly each other's highly trained health care professionals" (Kirby 2002a: 193). The Commission on the Future of Health Care in Canada notes every province in Canada has a history of recruiting health care workers especially from developing countries and registers ethical concerns. While not wanting to "curtail the right of individuals to seek a better life for themselves and their families," the point is made that "Canada has an ethical responsibility to ensure that it does not attempt to solve its shortages of health care professionals on the backs of less powerful, less wealthy and less developed nations" (Romanow 2002: 244).
187. Examples of this argument along the political spectrum may be found in (Barnet and Cavanagh 1994), (Castells 1997, 1998) (Friedman 2000) and (Yergin and Stanislaw 2002).
188. For accounts of "New World Syndrome" see (Shell 2001) and (McMurray and Smith 2001).
189. (World Bank 1993) For critical view of exporting managing care see (Iriart, Merhy, and Waitzkin 2001) and (Waitzkin and Iriart 2001).
190. (Castells 1996)
191. For example of telemedicine and telehealth applications, see (Tripler Army Medical Center 1998).
192. Examples of those who articulate concerns about trade liberalization include (Chossudovsky 1997) (Hahnel 1999) (Madeley 1999) and (Kim, Millen et al. 2000).

193. (Kim, Shakow et al. 2000) (Schoepf, Schoepf, and Millen 2000)
194. One example is the ongoing investigation into Tenet Healthcare where doctors are alleged to have performed hundred of unnecessary cardiac procedures and operations (Eichenwald 2003b).
195. (Reich 1991) (Wilson 1996) (Mishel, Bernstein, and Schmitt 2001).
196. Evidence supporting determinants of health may be found at Health Canada, Population Health:  
<http://www.hc-sc.gc.ca/hppb/phdd/determinants/determinants.html#income>
197. An example of an analysis of the “corporate campaign phenomenon” purportedly directed against “Healthcare: An Industry in Crisis” is by Jarol Manheim, Professor of Media and Public Affairs and Political Science at George Washington University (Manheim 1999).
198. (Crucible Group 1994) (Shiva 1997)
199. (Sanger 2001) (Lipson 2001) (Campbell et al. 2002) (Labonte 2003)
200. (Chen, Evans, and Cash 1999: 296-297)
201. An excellent example of denaturalizing a “natural event” by doing a “social autopsy” is Eric Klinenberg’s analysis of the deaths of over 700 people in excess of the weekly norm during the 1995 Chicago heat wave. He writes “the dead bodies were so visible that almost no one could see what had happened to them” (Klinenberg 2002: 123). Chicago Mayor Richard Daley was quoted as saying “It’s hot. It’s very hot. We all have our little problems but let’s not blow it out of proportion” (Klinenberg 1999: 239). Journalistic focus on the mounting bodies at the city morgue and trivializing the victims as elderly people who refused to seek help obscured a web of vulnerability caused by institutional violence of poverty, racism, and urban decay. In August of 2003 different but no less deadly social dynamics could be seen in the French heat wave that caused 15,000 deaths (Coleman 2003a). The Director General of Health, Dr. Lucien Abenhaim, resigned on August 18, 2003 when the death count was around 5,000 while still maintaining that “for the moment, it has not been demonstrated that errors were made” (Tagliabue 2003). An exceptional comment in the news coverage was made by Dr. Bernard Kouchner, a former health minister and founder of Doctors Without Borders. He noted the effects of global warming and needing health services closer to the ground and said the main lesson to be drawn from the deaths was “not a medical lesson, but a social lesson: You have to take care of your elderly...We were all guilty, in a way” (Tagliabue 2003).
202. (Schlosser 2001) gives a comprehensive account of these dynamics in his examination of fast food. Another compelling example is the E. coli O157:H7 and Campylobacteri jejuni outbreak from contaminated water in Walkerton, Ontario that made 2,300 ill and killed 7 people in May 2000. Failure of regulations, lack of oversight, privatization of laboratory services, and budget cuts were all contributing factors to this event (O’Connor 2002).

203. On September 10, 2003 the Canadian Health Coalition issued an “action request” on deregulation of health protection based on their view that “the unstated objective of the federal government is to bring health protection legislation in line with its international trade and economic policy objectives. Risk management will form the basis of the proposed new law instead of the Precautionary Principle” (Canadian Health Coalition 2003) <http://www.healthcoalition.ca/>, accessed September 15, 2003.
204. The percentage of people living below the poverty line in the United States increased from 12.1% in 2001 to 12.4% in 2002 and totaled 34.8 million people. There are 12.2 million children living in poverty. The rate of increase for children under 5 years increased a full percentage point from 18.8% in 2001 to 19.8% in 2002 (Clemetson 2003). After the events of September 11, 2001, New York City has 1.6 million people living below the poverty line (20.2% of the population) with another 13% barely above it. New York City’s poverty rate is 28% for Hispanics, 25% for African Americans, and 12% for whites. Homelessness has increased by 82% since 1998. Within this context, there are 800,000 residents of New York City who are eligible for food stamps in 2003 but do not receive them. There was a 42% drop in recipients in Mayor Rudolph Guiliani’s second term due to barriers to access that were intentionally created by an administration that described food stamps as a costly “welfare program” that increased a “culture of dependency” (Newfield 2003). More information on the practice of “churning” to decrease social assistance, welfare reform research and practice, and the privatization of public assistance may be found in (Schram 1995).
205. (Glazer 1993)
206. (Armstrong et al. 2002)
207. This figure of eliminated actual and potential jobs in the United States is attributed to net U.S. export deficit with Mexico and Canada. The \$16.6 billion U.S. net export deficit with Mexico and Canada in 1993 increased by 378% to \$62.8 billion in 2000 (in inflation-adjusted 1992 dollars) (Scott 2001b: 3).
208. (Salas 2001: 14)
209. (Salas 2001: 17-18)
210. (Campbell 2001: 23)
211. (Campbell 2001: 22)
212. (Campbell 2001: 28)
213. (Scott 2001b: 8). From 1989 to 1999, 98.9% of net new jobs in the United States have been in the service sector, where average compensation is only 77% of the goods producing sector (Mishel, Bernstein, and Schmitt 2001: 169).
214. (Salas 2001: 17)
215. (Salas 2001: 18)



216. (Campbell 2001: 24)
217. In addition to inhibiting unions, threats of capital flight also drive down wages (Scott 2001b: 8-9).
218. "The labor side agreement established the North American Commission for Labor Cooperation to implement that accord's principles and includes a process whereby citizens, groups, or governments can raise questions of labor law enforcement in all three member countries" (General Accounting Office 2001c: 4).
219. (Salas 2001: 19)
220. (General Accounting Office 2001c: 4) One such case was filed by Human Rights Watch, International Labor Rights Fund, and the National Association of Democratic Lawyers of Mexico concerning "alleged mistreatment or discharging of pregnant employees at a maquiladora plant to avoid paying maternity benefits." The case was open from May 16, 1997 to May 30, 2000 and was resolved by "ministerial agreement reached—one conference and two outreach sessions held to discuss and educate workers on their rights" (General Accounting Office 2001c: 55). It is significant that no mention is made of educating employers on their responsibilities.
221. (Campbell 2001: 25)
222. (General Accounting Office 2001c: 4)
223. This estimate is from the U.S. Trade Deficit Review Commission 2000: 110-118 and cited by (Scott 2001b: 9).
224. (Campbell 2001: 24)
225. (General Accounting Office 2001c: 5)
226. (McQuaig 2001: 11)
227. (Trade and Investment Research Project 2003: 4)
228. (Trade and Investment Research Project 2003: 6)
229. (Trade and Investment Research Project 2003: 1)
230. (Trade and Investment Research Project 2003: 3)
231. (Trade and Investment Research Project 2003: 7)
232. (Trade and Investment Research Project 2003: 1)
233. Information on the Population Health approach by Health Canada is available at: <http://www.hc-sc.gc.ca/hppb/phdd/approach/index.html>

234. The World Health Organization Regional Office for Europe has “embarked on a campaign to promote awareness, debate and action on the social determinants of health” (Marmot and Wilkinson 1999: 278). In collaboration with the World Health Organization and the International Center for Health and Society at University College London, this campaign is being promoted through the European region by the WHO Healthy Cities project. The Healthy Cities Europe booklet entitled *Social Determinants of Health: The Solid Facts* (Wilkinson and Marmot 2003) is available from: [http://www.who.dk/eprise/main/who/InformationSources/Publications/Catalogue/20020808\\_2](http://www.who.dk/eprise/main/who/InformationSources/Publications/Catalogue/20020808_2) The material is consistent with their early book on this topic (Marmot and Wilkinson 1999).
235. Not everyone would agree, of course. The impact of globalization on poverty, income inequalities, and wealth inequalities is another example of “contested narratives of globalization.” Sala-I-Martin (2002) argues that income inequality has improved globally over the last two decades, Dowrick and Akmal (2001) suggest that global income inequality is essentially unchanged, and (United Nations Development Programme 2003: 39) gives evidence for it being worse, while acknowledging the controversies.
236. Gini coefficient (also known as the index of income concentration) ranges from 0.0, when all households have equal share of income, to 1.0, when one household has all the income and the rest none (Jones and Weinberg 2000: 1).
237. Examples of this literature would include (Wilkinson 1996, 2001), (Marmot and Wilkinson 1999), (Kawachi, Kennedy, and Wilkinson 1999; Auerbach and Krimgold 2001).
238. Italics found in the original citation. Stuart Ewen’s careful analysis of the trajectory of the public relations industry is titled *PR! A Social History of Spin* (1996).
239. Diana Zuckerman describes “checkbook science” as “research intended not to expand knowledge or to benefit humanity, but instead to sell products” (2003a: 383).
240. The Independent Institute “sponsors comprehensive studies on the political economy of critical social and economic problems. The politicization of decision making in society has largely confined public debate to the narrow reconsideration of existing policies....The Independent Institute’s program adheres to the highest standards of independent inquiry and is pursued regardless of prevailing political or social biases or conventions” Academic advisors include scholars from institutions of higher education as well as from the conservative American Enterprise Institute, Cato Institute, and the Brookings Institution. This information is taken from an unpaginated section of (Feldman 2000) which argues for market approaches to American health care.
241. The trajectory of declining numbers of media corporations through various editions of *Media Monopoly* was traced by (Bennett 2003: 95). The six parent firms that dominate American media as of 2000 are General Electric, Viacom, Disney, Bertelsmann, Time Warner, and Murdoch’s News Corp (Bagdikian 2000: x).

*Columbia Journalism Review* has an ongoing project of listing “Who Own What” on its website: <http://www.cjr.org/tools/owners/>

242. This comment was made on September 4, 2003 during an interview on “Morning Edition” on National Public Radio. Mark McClellan is board certified in Internal Medicine and has a PhD in Economics. Prior to his swearing in at the Food and Drug Administration on November 14, 2002, McClellan was an Associate Professor of Economics at Stanford University and Associate Professor of Medicine at Stanford Medical School. His biographical information was accessed September 19, 2003 at <http://www.hhs.gov/about/bios/fda.html>. It is also pertinent that Dr. McClellan was “a health specialist in the Bush White House” prior to his FDA appointment and his brother, Scott McClellan, replaced Ari Fleischer as White House spokesperson in July 2003 (Coleman 2003b). McClellan became the Administrator for the Centers for Medicare and Medicaid Services on March 25, 2004, accessed September 30, 2004: [http://www.cms.hhs.gov/about/leadership/more\\_mcclellan.asp](http://www.cms.hhs.gov/about/leadership/more_mcclellan.asp)
243. This line is part of a speech by Macheath, known as “Mac the Knife,” on his way to the gallows. *The Threepenny Opera* (words by Bertolt Brecht, music by Kurt Weill) was based on a translation of John Gay’s *Beggar’s Opera* and was “the hit of the season” when it opened in 1928. The cited line is from (Brecht 1987: 138).
244. Joel Lexchin, MD practices emergency medicine in Toronto and is an associate professor in the School of Health Policy and Management at York University. He recently collaborated with other scholars associated with the Consortium on Globalization and Health, Canadian Center for Policy Alternatives, on a background paper examining trade treaties and health for the Romanow Commission (Campbell et al. 2002).
245. Many of the multinational corporations (such as Merck) had offices, manufacturing, and research facilities in the Montreal area. They promised further investment in return for changes in Canadian patent legislation. Federal politicians did not want to alienate their constituents or provincial allies in Quebec by opposing the industry (Lexchin 2001: 35).
246. Ed Pratt “systematically went about putting intellectual property rights onto the GATT agenda. He first formed alliances with the US motion picture and computer industries and helped form the ‘Intellectual Property Rights Committee’ (IPC), which consisted of 13 major US corporations. Then, with the encouragement of Clayton Yeutter, Pratt sought allies in Europe and Japan and eventually won over the two major umbrella industrial organizations—UNICE (the Union of Industries of the European Community) in Europe and Keidanren in Japan” (Lexchin 2001: 35).
247. “A compulsory license is essentially a permit that effectively negates a patent” (Lexchin 2001: 31). It dates back to 1923 in Canada when the Patent Act was amended to encourage multiple companies to manufacture the same drug to encourage competitive pricing. As the Canadian market was too small to support a manufacturing facility and the law stipulated that the drug be manufactured in Canada, this amendment was not successful. In the 1960’s three reports identified patent protection as a major reason for Canada having drug prices that were among the highest in the world. The Liberal government enacted Bill C-102,

which allowed companies to receive a license to import a drug into Canada as an extension of compulsory licensing. The Pharmaceutical Manufacturers Association of Canada mounted an “intensive lobbying and propaganda effort” which was not successful (Lexchin 2001: 31-32). The Patented Medicine Prices Review Board has regulated the prices charged by manufacturers of patented drugs since 1987 (Kirby 2002b: 19).

248. C-91 was made retroactive to apply to any product license granted after December 20, 1991. Observers noted that this date was set in an attempt to offer extended protection to Vasotec, worth an estimated \$700 million to Merck Frosst (Rachlis and Kushner 1994: 148).
249. “Nova Scotia’s Dalhousie University, for example, was embroiled in a controversy after a Liberal provincial MLA linked a research grant to the Faculty of Health Professions of \$1.3 million with a letter from the dean supporting the bill. In fact, explained the dean of the faculty, Dr. Lynn McIntyre, there was no connection. The money had been received before the university even thought of writing the letter. But she acknowledged that “there are cases where drug companies have made contracts conditional on support—for sure” (Rachlis and Kushner 1994: 148).
250. Rachlis and Kushner state that some voluntary organizations “were warned, unofficially, that donations to them from the industry could be contingent on their support of Bill C-91” (1994: 148).
251. “Spending on drugs has grown from \$3.8 billion in 1985 to \$15.5 billion in 2001. During this 16-year period, data from CIHI show that spending on drugs has grown faster than inflation and beyond the rate attributable to population growth. More precisely, from 1985 to 1992, drug expenditures increased on average by 12% annually” (Kirby 2002a: 126).
252. In an interview with Korva Coleman on “Talk of the Nation,” Marc Kaufman who covers the Food and Drug Administration for the *Washington Post*, described conflict of interest as follows: “I think this is something that, over time, as people come to understand more and more that it is the case, that industry is funding many of the FDA’s major roles, I can’t help but think that it will be controversial. And if there are cases that come up where drugs or devices do turn out to be unsafe, the fact that the people who made the decisions were getting their funding potentially from the company indirectly seems to me to be a big issue. You should know that this began with pharmaceuticals back, I think in 1994. Two years ago, medical devices joined in the same kind of user fee program, and then just this year, animal health, veterinary drugs also did. So the trend is to do this more and more. And in each of these FDA centers, they have more of the budget done through user fees. Some people at the FDA would say the alternative is that we will just not have enough people to do anything” (Coleman 2003b).
253. Dr. Mark McClellan, commissioner of the Food and Drug Administration, has made speeding up new drug approvals and encouraging new drug development as top priorities on his agenda (Edwards 2003c). Some, like Peter Vandoren of the Cato Institute, would argue that any regulation is too much: speaking of the Food and Drug Administration Vandoren says “well, in Cato heaven, it probably

wouldn't exist" (Coleman 2003b). Critics of Canada's Health Protection Branch, such as the Canadian Medical Association, have noted that Canada's drug review process is significantly slower than other countries. For example, between 1996 and 1998 the median approval time for Canada was 518 days compared with median approvals times of 371 days for Sweden, 369 days for the United States, and 308 days for the United Kingdom. Described as a "major breakthrough in asthma therapy," fifteen other countries approved Singulair before it was approved in Canada, even though the drug was developed in Montreal (Patel 2003: 5). Elinor Burkett, a passionate critic of the "AIDS Industrial Complex," traces the conflict between access to medications for HIV disease and safety in *The Gravest Show on Earth: American in the Age of AIDS* (1995).

254. This figure is in Canadian dollars. Direct comparisons between the two countries is often not exact in that slightly different elements may be included in categories for each country as well as differences in purchasing power parity.
255. This point is often made by Robert Evans. PhD, Professor of Economics at the University of British Columbia. For example: "Every dollar of expenditure is a dollar of someone's income. This relationship is not 'approximately true', reflecting the fact that health is a labour-intensive industry. It is *exactly* true (1999: 35).
256. This data is from the Patent Medicine Prices Review Board, *A Study of the Prices of the Top Selling Multiple Source Medicines in Canada*, November 2002. It was cited by (Patel 2003: 3).
257. A particular tax-avoiding strategy said to be popular with pharmaceutical and computer companies has been described as "parking intangibles overseas." Anderson et al. argue: "...this tax dodge works by transferring intellectual property such as patents and trademarks to offshore subsidiaries. The offshore unit then charges a licensing fee or royalty for use of intellectual property, and this escapes U.S. taxation" (2003: 18).
258. <http://www.pfizer.com/>
259. <http://www.gsk.com/>
260. <http://www.merck.com/>
261. The Disease Management Association of America describes itself as a "non-profit, voluntary membership organization" which "represents all aspects of the disease management community." This organization defines disease management as "a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physicians or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health." The officers and board of directors are representative especially of the health care and insurance industries:

President	Robert Stone	American Healthways
President-Elect	Samuel Nussbaum, MD	Anthem Blue Cross Blue Shield
Past President	Jonathan Lord, MD	Humana, Inc.
Treasurer	Rose Maljanian	Hatford Hospital
Secretary	Cheryl Neel	Blue Cross Blue Shield
Ex. Director	Warren Todd	Disease Management Resources
Director	Steven Brown	Health Hero Network Inc.
Director	Russell Ellison, MD	Sanofi-Synthelabo
Director	Don Fetterolf, MD	Highmark BCBS
Director	Pamela Hightower	Advance PCS
Director	Kelly Jenkins	Federal Express
Director	Susan Jennings	Pfizer Health Solutions Inc.
Director	Paul Kaplan, MD	Blue Cross Blue Shield of Delaware
Director	Al Lewis	Disease Management Purchasing
Director	David Nash, MD	Thomas Jefferson University Hosp.
Director	William Popik, MD	Aetna Health Plan
Director	Ginny Proestakes	General Electric
Director	Marcia Rowan	Health Management Corp.
Director	Mark Santry	GlaxoSmithKline
Director	Christobel Selecky	LifeMasters Supported SelfCare Inc.
Director	Jann Didorov, MD	Geisinger Health Plan
Director	Richard Vance, MD	CorSolutions, Inc.
Director	Sandeep Wadhwa, MD	McKesson Health Solutions
Director	Allen Woolf, MD	Intracorp
Director	David Wynstra	Healthcare First

The mission of Disease Management Association of America is to “advance Disease Management through standardization of definitions, program components and outcome measures, promote high quality standards for disease management programs, support services and materials; and, educate consumers, payers, providers, accreditation bodies, and legislators on the importance of Disease Management in the enhancement of individual and population-based health.”

Information accessed December 5, 2003 at <http://www.dmaa.org/>

262. The main “Arthritis Canada” portal is found at the maple leaf logo at the top right hand corner of the Arthritis Society webpage <http://www.arthritis.ca>.
263. The Arthritis Society of Canada website accessed December 4, 2003 at: <http://www.arthritis.ca/>
264. Within the page devoted to Pfizer sponsorship the copy reads: “Pfizer Canada Inc. is committed to improving the lives of people with arthritis.” “This commitment” is then argued to be demonstrated by sponsorship of the Arthritis Society webpage, the Arthritis Society’s Arthritis Self-Management Program “designed to help people with arthritis take a more active role in their arthritis care,” 16 Arthritis Center at each of the medical schools in Canada, and “Patient Partners® in Arthritis” described as “an innovate medical education program designed to improve the healthcare providers ability to diagnose and manage arthritis. Patients with arthritis demonstrate and evaluate the full body musculoskeletal examination in teaching situations with healthcare providers and medical students.” From the “Meet Our Sponsors” webpage

(<http://www.arthritis.ca/support>), the Pfizer Canada Inc. is only one click away (<http://www.pfizer.ca>).

265. Sheila Slaughter and Larry Leslie, for example, argue that shifts in the financial support of academic institutions change the nature of academic labor. They define "academic capitalism" as "institutional and professional market or marketlike efforts to secure external moneys" (Slaughter and Leslie 1997: 8).
266. Canadian Arthritis Network accessed December 4, 2003 at <http://www.arthritisnetwork.ca/>
267. Canadian Arthritis Network accessed December 4, 2003 at <http://www.arthritisnetwork.ca/about/history.asp>
268. Canadian Arthritis Network accessed December 4, 2003 at <http://www.arthritisnetwork.ca/about/index.asp>
269. "The Pre-clinical Resources program facilitates the translation of pre-clinical science to clinical science for industry. Whether you need to evaluate potential anti-arthritis drugs for clinical use or reevaluate the mechanism of action for drug candidates, the Network's highly qualified experts can develop and implement specific protocols to meet your needs." Resources include in vitro diagnostic and screening systems, animal models, analytical services (histopathology, gross morphology, immunohistochemistry, immunology, clinical biochemistry, molecular genetics, cytogenetics, etc), and expert consultants on protocol design, method validation, and data analysis. [http://www.arthritisnetwork.ca/products and services/pre clinical.asp](http://www.arthritisnetwork.ca/products_and_services/pre_clinical.asp)
270. The mission of the Canadian Rheumatology Research Consortium is "to facilitate the conduct of rheumatology clinical research in Canada. Our commitment to improving the quality and efficiency of clinical research will enhance Canada's competitiveness in the global marketplace and ensure that arthritis patients have early access to novel and effective treatments." Advertising "bench-to-bedside expertise" services include phase I, II, and III clinical trials, centralized site selection and budget negotiation, consulting in clinical development, advisory boards, data safety monitoring boards, trial design and evaluation. [http://www.rheumtrials.ca/english\\_services.htm](http://www.rheumtrials.ca/english_services.htm)
271. Health Research Services has positioned itself to "support industry, government and academia in achieving their research objectives" by providing such services as: pharmaeconomic analysis, socio-economic analysis, biostatistical analysis, quality of life and therapeutic effectiveness studies, utilization and review monitoring, disease surveillance, and broad consulting services. [http://www.arthritisnetwork.ca/products and services/health services.asp](http://www.arthritisnetwork.ca/products_and_services/health_services.asp)
272. Listed academic and clinical partners include: Arthritis Research Center of Canada, Centre hospitalier affilié universitaire du Québec, Centre hospitalier de l'Université de Montréal, Dalhousie University, École Polytechnique, Hôpital Sainte-Justine, Hospital for Sick Children, Institut national de la recherche scientifique, Université du Québec, Institute for Biological Sciences, National

Research Council Canada, Jewish General Hospital/Lady Davis Institute, Robarts Research Institute, London Health Science Centre, McGill University, McMaster University, Memorial University of Newfoundland, Montreal General Hospital, Mount Sinai Hospital, Toronto, Ottawa Hospital, Providence Health Care, Queen's University, Royal Victoria Hospital, Shriners Hospital for Children, St. Joseph's Health Centre/Lawson Research Institute, St. Joseph's Hospital, Hamilton, St. Justine Hospital, Montreal, St. Michael's Hospital, Toronto, Sunnybrook & Women's College Health Sciences Centre, Université de Montreal, Université de Sherbrooke, Université Laval, University Health Network, University of Alberta, University of British Columbia, University of Calgary, University of Guelph, University of Manitoba, University of Ottawa, University of Toronto, University of Waterloo, University of Western Ontario.

273. Companies listed as "affiliate members" include: Abbott Immunology, Allergan Inc., Anacoti Ltd., Aventis Pharma, Biophage Pharma, Biosyntech Inc., Boehringer Ingelheim (Canada) Ltd., Brogan Inc., Centocor, ClinTrials BioResearch Inc., Ellipsis Biotherapeutics Corp., Enhanced Vision Systems Corp., Farnham Companies Inc., IBEX Diagnostics, Immundiagnostiks AG, IMS Health Canada, Johnson & Johnson, Merck Frosst Canada & Co., Milestone Medica Corp., Novartis Pharmaceutical Canada Inc., Ortho-Biotec, Pfizer Canada, Pharmacia Canada, Proctor & Gamble Pharmaceuticals Canada, Roche Biosciences, Rx&D, Stryker-Osteonics-Howmedica, Transition Therapeutics Inc., and Wyeth Pharmaceuticals.
274. Other affiliated government and non-profit organizations include: Anemia Institute, Arthritis Community Research and Evaluation Unit, Canadian Foundation for Innovation, Canadian HIV Trials Network, Canadian Institutes of Health Research, Centre for Health Evaluation and Outcomes Science, Foundation Armand-Frappier, Fonds de la recherche en santé du Québec, Health Canada, Institute of Musculoskeletal Health and Arthritis, Ontario Ministry of Long-Term Care, and The Arthritis Society.
275. Accessed September 27, 2003 <http://www.pfizer.com/main.html>
276. Accessed September 27, 2003 [http://www.merck.com/about/feature\\_story/06192003\\_hiv\\_botswana.html](http://www.merck.com/about/feature_story/06192003_hiv_botswana.html)
277. Accessed September 27, 2003 <http://www.securethefuture.com/>  
This site includes the following quotation: "Ultimately, our actions will not be measured in dollars alone, but in the sustainability of the programs we support and in the enduring empowerment we provide to the people, the communities and the countries we seek to help" John McGoldrick, Executive Vice President, BristolMyersSquibb. McGoldrick's total compensation in 2001 was \$3,637,392 plus total unexercised stock options of \$19,451,608 (Families USA Foundation 2002: 29).
278. This story circulates back to the Bill and Melinda Gates Foundation illustration from Chapter Two. Garnier continues his discussion of malaria by discounting government and then valorizing the Gates Foundation and his company: "As we looked at this, we felt there had to be a way to do it. Apart from for-profit research, a second way is non-for-profit research, funded by government from taxpayer money. That hasn't produced anything, of course. Take Russia after



years of doing research, they've never found a single drug. And they had plenty of money and good science....In the case of malaria, we went to Bill Gates. We said, "Bill, if you give us the money, we believe we can develop the malaria vaccine. Here's the evidence. We've made the first investment ourselves, and we're showing some good results. But we need to move into large scale clinical trials. It's like show and tell, but we're asking for money. Bill Gates gave us some money. So the Bill and Melinda Gates Foundation and others are paying for development of the malaria vaccine...The model we found was a good model, a good hybrid. We provide the science pro bono, more or less...We are a classic case of a company that found a way to do these kind of things, and it's good for everybody. It's certainly good for the beneficiaries. This is a model that is sustainable, one that can coexist with the for-profit purpose of the corporation. It's tremendously motivating for our employees to know that we're generous and that we're a company with a soul" (Iglehart 2003).

279. Fran Hawthorne writes in her introduction to *The Merck Druggernaut: The Inside Story of a Pharmaceutical Giant* that she "seriously debated using the subtitle "The Last Good Drug Company" (2003: xii).
280. More than half (53%) of new drugs approved by the U.S. Food and Drug Administration between 1981 and 1991 were "copycat" or "me-too" drugs with little or no therapeutic value. After 1992, the Food and Drug Administration under the Bush Administration eliminated the 1A-1C ranking system that revealed the presence of me-too drugs in response to industry pressure (Public Citizen 2002: 49). From 1989 to 2000, 65% of the new drugs approved by the Food and Drug Administration were for drugs that contained active ingredients available in products already on the market. Only 24% of FDA approvals from 1989 to 2000 were eligible for FDA's priority review (a review process for drugs that offer a significant clinical advance) (Families USA Foundation 2002: 11).
281. In the twelve months ending June 2003, sales for the C10 hypolipidima class were \$20.8 billion with 66% of sales in the United States and 20% in the leading five European countries (IMS Health).
282. Part of the difficulty with this research is that drug companies actively refuse to disclose research and development data. The General Accounting Office tried to obtain data on drug company research and development but was "ultimately foiled after nine years of effort that involved a decision in the U.S. Supreme Court" (Public Citizen 2002: 47).
283. Illustrative research include the following: Pharmaceutical company sponsored studies were less likely than nonprofit sponsored studies to report unfavorable qualitative conclusions (1/20 [5%] vs 9/24 [38%];  $P = .04$ ) in a review of 44 articles on new drugs used in oncology (Friedberg et al. 1999). Authors who supported the use of calcium-channel antagonists were significantly more likely than neutral or critical authors to have financial relationships with manufacturers of calcium-channel blockers (96 % vs 60% and 43% respectively,  $P < 0.001$ ) (Stelfox et al. 1998). Symposia sponsored by a single drug companies had more articles without method sections (10%, 108 of 1064) than did symposia that had other sponsors (3%, 58 of 2314) or symposia with no mentioned sponsor (2%, 29 of 1663) ( $P < 0.001$ ). Articles with drug company support (98%, 39 of 40) were

more likely than articles without drug company support (79%, 89 of 112) ( $P = 0.01$ ) to have outcomes favoring the drug of interest (Cho and Bero 1996).

284. HMSA Hawaii (Blue Cross Blue Shield of Hawaii) sent out inserts with comparative informative between generic and brand name drugs to members with their statements in the Fall of 2003. Prescription drugs costs accounted for 22% of all HMSA benefits paid or \$236 million in 2002 (Nishimura 2003). Nishimura reports that nearly 43% of prescriptions filled by HMSA members are currently for generic drugs.
285. Hawthorne's research explains that sometimes a lunchtime crowd that includes clerical workers as well as clinical staff at a doctors' office can reach 25 to 40 people (2003: 127) which might help explain the high cost of lunch.
286. In response to (Moynihan 2003), here are two illustrative examples. A final year medical student from London writes: "If drug companies want to come and give us a free lunch and promote their drug, so what? If we are weak minded enough to let this influence us then we are not putting what we have learnt into practice from our epidemiology (sic) lectures at all. In the evaluating the evidence of studies funded by drug companies we all know that these studies are going to have an inherent bias and thus must be taken with a pinch of salt" (Beggs 2003). An Assistant Professor of Family and Community Medicine affiliated with the University Physician Group of Palmyra, PA who is a consultant for and lectures on behalf of several pharmaceutical companies argues that in the midst of being faced with a "multitude of ethical dilemmas daily," "listening to constitutionally protected free speech" is just another instance. His conclusion is: "Despite my opinion that doctors should be able to receive promotional information objectively and without undue influence, I will agree to refuse all gratuities from the pharmaceutical industry and will encourage the professional societies to which I belong to eschew all pharmaceutical support ONLY when members of Congress refuse all contributions designed to influence their decision making. If it's wrong for us, it is certainly wrong for them" (Messmer 2003).
287. Sampling = the value of samples left at sales visits to office-based physicians. The samples are valued at the prices they would be sold in retail pharmacies.
288. Detailing = expenses for sales activity of pharmaceutical representatives directed to office-based and hospital-based physicians. Approximately 83% of this spending is for office-based sales visits.
289. Direct-to Consumer Advertising = expenditures for magazine, newspaper, radio, and television advertising targeted towards consumers.
290. Professional Journal Advertising = expenditures for advertising prescription products in medical journals.
291. Fran Hawthorne's interviews with physicians and pharmaceutical industry insiders portrays the finer points of detailing in Chapter Five, "The Freebie Circuit," in her book *The Merck Druggernaut: The Inside Story of a Pharmaceutical Giant*. The following conversation with an internist in a large American city conducted by Hawthorne in the winter of 2002 is fascinating for its tone: "I get invited out to restaurants I could not otherwise afford" by salespeople from big

pharmaceutical companies a few times a month, he shrugged, naming four upscale places in his city. The reps call and ask, "Is there anything I can do for you? Do you want to go to the theatre some evening?" I've let them know I prefer [classical music]. They say, "I'll see what I can do." The things I'm asking for are all very reasonable. I'm not asking for last-minute, front-row seats." On the drug companies' tab, he's seen "The Vagina Monologues," and Schubert, Wagner, Beethoven, and Mahler concerts. Along with several doctors, their guests, and the sales rep, he might go to two shows every six months, plus dinner. He figures it had to cost hundreds of dollars each time. They never talk about medicine. "Obviously, it's all very informal. We just go there and enjoy." Then, when it comes time to write prescriptions, "I try to give everyone a little piece of the pie. If I like the rep, they get a little more. Some of them have said to me, 'Two prescriptions a month would make a big difference to us.'" So he'll give that rep the extra business one month, as long as the rep's drug is basically the same as whatever else he might have prescribed. "Another company will get it next time." Once, the internist recalled, he asked a rep for tickets to a particular show. The rep "never called me back. His drug [competes with] other drugs that are very similar, so guess what? He's not going to get many prescriptions from me." According to the pharmaceutical industry, everything the internist described doesn't happen (2003: 115-116).

292. Dr. Frank Riddick, chair of the American Medical Association's Council on Ethical and Judicial Affairs, explains that under AMA guidelines physicians are entitled to accept gifts of low value (\$100 or less) if they serve educational, practice related, or patient care functions (Spurgeon 2002).
293. A similar scenario is the Queen City Physicians group in Cincinnati that set up a subsidiary company called Physician Access Management. They charge drug representatives \$65 each time to talk with one of their physicians for 10 minutes. The proceeds are then used to pay for an electronic medical records system (Spurgeon 2002).
294. This is controversial to the extent that it received notice by the *Wall Street Journal* and serves as a case study to generate discussion on professional ethics with house staff at the University of Toronto medical school (Gordon 2003).
295. This program was not open to Canadian physicians as the drug was still undergoing regulatory review in Canada (Zuckerman 2003b).
296. "Rather than "perplexing" the *Wall Street Journal* described Biovail's behavior as "unusual" and "bizarre" in October 2003. A team of pharmaceutical analysts headed by David Maris released a report on Biovail on October 8, 2003 that sent its stock down almost 14%. In the jargon of the *Wall Street Journal*: "for years, Biovail has attracted short-sellers who assail the company's accounting practices, product hype and acquisition strategy. Nevertheless, Biovail had singed the shorts, stringing together years of financial reports that appeared strong and drove the stock higher" (Eisinger 2003). What attracted Maris's interest was Biovail's warning about earnings and revenue related to a serious traffic accident outside of Chicago. The involved truck was filled with "roughly \$10 million to \$20 million" of Biovail's depression medicine, Wellbutrin XL. Maris contacted the Illinois police about this truck crash story and videos of the accident scene seem to show that the truck was "nearly empty." Analysts said that shipping

merchandise that equates roughly to 5-10% of the company's quarterly product revenue on the last day of the quarter is itself "a yellow flag." In return, Biovail said that the Maris report was "filled with inaccuracies and written irresponsibly" (Eisinger 2003).

297. Moynihan (2003: 1190) list of entanglements between the global pharmaceutical industry and physicians includes:
- Face to face visits from drug company representatives
  - Acceptance of direct gifts of equipment, travel, or accommodation
  - Acceptance of indirect gifts, through sponsorship of software or travel
  - Attendance at sponsored dinners and social or recreational events
  - Attendance at sponsored educational events, continuing medical education, workshops, or seminars
  - Attendance at sponsored scientific conferences
  - Ownership of stock or equity holdings
  - Conducting sponsored research
  - Company funding for medical schools, academic chairs, or lecture halls
  - Membership of sponsored professional societies and associations
  - Advising a sponsored disease foundation or patients' group
  - Involvement with or use of sponsored clinical guidelines
  - Undertaking paid consultancy work for companies
  - Membership of company advisory boards of "thought leaders" or "speakers' bureaux"
  - Authoring "ghostwritten" scientific articles
  - Medical journals' reliance on drug company advertising, company purchased reprints, and sponsored supplements
298. A drug industry example of "third party" advocacy in a grass-roots coalition format is that Pfizer launched an advertising campaign for Viagra with the public relations support of Hill & Knowlton by creating a front group called Impotence Australia. Pfizer bankrolled Impotence Australia in the amount of \$200,000 Australian dollars (U.S. \$121,000) but the campaign hit a snag when the undisclosed ties to Pfizer were leaked in *Australian Doctor* and the *Australian Financial Review* (Burton and Rowell 2003: 2).
299. The Society for Women's Health Research describes itself as "the nation's only non-profit advocacy group whose sole mission is to improve the health of women through research." Accessed September 28, 2003  
<http://www.womens-health.org/>
300. This website provides a variety of citations documenting the influence of drug company promotions on medicine, a pen amnesty program, and a bit of solidarity for those wary of current marketing practices.  
<http://www.nofreelunch.org/>
301. Dr. Ronald Germain was "a paid advisor to a dozen drug-development companies, a law firm that specializes in patent litigation and an investment fund that buys and sells biotechnology stocks" (Willman 2003). Germain pointed out that "I have a well-regarded reputation both inside and outside of NIH for adhering strictly to the rule preventing me from revealing or using specific knowledge of my NIH research during consulting activities and for keeping all outside activities from having any bearing on the conduct of my activities as a

[government] employee...His consulting work also provides his family with 'greater financial security,' he said. 'This is of special importance to me because as a former Hodgkin's lymphoma patient, it was difficult until recently to obtain adequate life insurance coverage while being at increased risk for an early death'" (Willman 2003).

302. "Under the panel's recommendations, Deutsch said, NIH would retain conflict-of-interest policies amounting to "a system of careful twisting of the rules and overlooking of the consequences." "It is a report from a panel that blatantly refused to consider the most important facts," Deutsch said. "The panel apparently felt compelled to base its recommendations on their misplaced need to excuse the inexcusable." The co-chairmen of the panel, Bruce Alberts and Norman R. Augustine, said at the hearing that they were convinced that allowing paid-industry consultancies might help NIH attract or retain talented scientists (Willman 2004).
303. In 1958 staff members of Senator Kefauver's Senate Committee on Antitrust and Monopoly, John Blair and Irene Till (both economists formerly with the Federal Trade Commission's Division of Economic Reports), were interested in the profit margins of the pharmaceutical industry. They noted profits of 18.9% of invested capital after taxes and 10.8% of sales after taxes. Till said, "It was unheard of for a whole industry to have profits like that" (Harris 1964: 17). On further study they found that Carter Products, American Home Products, and Smith, Kline & French had net profits of 38.2%, 33.5%, and 33.1% respectively. "That meant, for instance, that Carter's net profit before federal corporation taxes of fifty-two per cent was about seventy-five per cent—an unheard-of-figure," said John Blair (Harris 1964: 34). This profit was explained by detective work done by the committee that discovered the 1958 production costs of prednisolone (including tableting, bottling, and a profit) was 1.567 cents per tablet but the druggist paid 18 cents per tablet and the consumer 30 cents per tablet (Harris 1964: 38-39). The mark-up then that was highly publicized from the 1.57 cent per tablet cost to 17.9 cents per tablet to the pharmacist was 1,118 per cent (Harris 1964: 60). When questioned about a mark-up of 7,079 per cent for estradiol progynon, purchased in bulk from France and merely repackaged, Francis Brown, President of the Schering Corporation said to Kefauver: "You seem wedded to a question of percentages," and added that the subcommittee's figures left out Schering's expenses for "selling," "manufacturing," "informational work," "advertising," "informing the medical profession," "development work," and "research." "You did no research on this drug," Kefauver said. "You bought a finished product from Roussel. All you did was put it in a tablet, put it out under your name, and sell it at a markup of 7,079 per cent" (Harris 1964: 62).
304. This book opens with a Washington lawyer, Walton Hamilton, being prescribed an antibiotic for a streptococcal throat infection in 1951. Hamilton's physician gave him a script for a new "wonder drug" called Chloromycetin, which he was outraged to find would cost him eight dollars for a four day supply of the drug. When Hamilton phoned his doctor to see if he could prescribe something less expensive, he found out that the three drugs suitable for his condition all cost exactly the same price although manufactured by three different companies. Hamilton, formerly a consultant with the Antitrust Division of the Department of Justice, complained to his spouse, Irene Till, who was then working at the Federal Trade Commission (Harris 1964: 3-4). This incident is the foreshadowing

for Till's later response in 1957 and 1958 of "drugs" as the response as a staff member to the question of what should the Senate Subcommittee on Antitrust and Monopoly look at next (Harris 1964: 14-15). Although \$8 might not seem a significant sum in 2003, in 1951 dollars it would be equivalent to \$57.52 in 2002 dollars (using an inflation calculator found at <http://www.westegg.com/inflation/infl.cgi>).

305. Hearing anecdotal complaints from consumers about higher prescription drug prices in the United States than equivalent drugs in other countries, Senator Kefauver wrote to the State Department to ask foreign consulates to check on prices within their host countries (Harris 1964: 32). Kefauver collected a variety of data from the State Department that proved this proposition. Just to take one example, Merck was selling its brand of prednisone in England, through a subsidiary, for less than half what was charged in the United States (Harris 1964: 73).
306. Just to describe one of many examples of unethical advertising, John Lear, science editor of the *Saturday Review*, published an influential article in the January 3, 1959 issue that helped to spur and expand the range of Kefauver's investigations. A physician showed a folder advertising an antibiotic called Sigmamycin put out by Chas. Pfizer, Inc. "Across the top of the folder was a banner of bold type that said, 'Every day, everywhere, more and more physicians find Sigmamycin the antibiotic therapy of choice.' Below that were reproductions of what appeared to be the professional cards of eight doctors around the country, with addresses, telephone numbers, and office hours." When the physician Lear interviewed tried to contact each of those eight physicians by mail to ask them about their clinical outcomes, all eight pieces of mail were returned. Lear wrote, telegraphed, and tried to phone each doctor only to find out that the addresses and phone numbers were fake (Harris 1964: 19).
307. Harris writes of the alliance between the American Medical Association (AMA) and the Pharmaceutical Manufacturers Association (PMA): "It was widely reported at the time that the AMA had made an agreement with the PMA to fight the drug bill if the PMA would help defeat the medical-care bill, but, according to an article that appeared in the July 14, 1961, issue of *Science*, the AMA may have had reasons of its own for opposing S. 1552. "It would, if it serves its purposes, sharply reduce the amount of [drug] promotion," the article pointed out, "and this would reduce the AMA's own resources, since the AMA, in fighting the increasingly expensive battle against a government-financed health service, has come to rely heavily on the money its journals earn from drug advertising" (Harris 1964: 124). The "most comprehensive presentation of the drug industry's case" was by the President of the Pharmaceutical Manufacturers Association, Dr. Austin Smith (Harris 1964: 112). During the 1950's Smith was the editor of the American Medical Association membership publication, *Journal of the American Medical Association*, and was successively president of PMA, chairperson and chief executive officer of Parke, Davis & Co., and vice chair of the board of Warner Lambert Co. (Campion 1984: 492). Kefauver was well able to respond to a number of claims made by Smith that seemed to be disingenuous. The first example was Smith's assertion: "There isn't any disease left, to my knowledge, that the pharmaceutical industry is not in some way attempting to attack today." Kefauver responded: "Despite the

urgency of the struggle to find cures for cancer, research in this field by the industry had been seriously delayed by disputes with the government over patent rights" (Harris 1964: 114). The second example goes back to an article that Smith had written for the *Journal of the American Medical Association* in 1944 in which he described the "enormous" profits to be made from proprietary medicines and condemned "the absurd practice of prescribing" them when cheaper equivalents were available. Kefauver said, "At that time, you were working for the American Medical Association, and the American Medical Association had been very interested in less expensive drugs so that the doctor can have an interest in the economic welfare of his patient. So, at that time, you recommended generic names. And now you are working for the manufacturers, and you recommend trade names. Does that have anything to do with it?" "I think, Mr. Chairman, we might make one thing clear right now," Dr. Smith said sharply. "For years, since I have been in professional practice, one type or another, my time and my knowledge have been purchasable, but I never have" (Harris 1964: 115-116). As a statement whose ambiguity is only matched by its self-righteous, one can only imagine what this means. On the day-to-day level, this investigation also noted the importance of pharmaceutical representatives as Santa figures: "Plenty of doctors are crazy about detail men," he explained. "In small towns they not only bring doctors free samples and information but open their bags and give them presents of all sorts—illuminated anatomy figures, monogrammed golf balls, and so on. They're regular Santa Clauses" (Harris 1964: 92).

308. Harris's book, *The Real Voice*, is divided into three parts: the investigation, the hearings, and the bill. The last third of the book gives an account of lobbying and power dynamics through the bill's movement through the House, Senate, and into a Senate-House conference that confirms every cliché about the wisdom of averting one's eyes as laws (and processed meat products) are made. Accounts of the passage of the Medicare reform bill are even more unbecoming. Moving beyond substantive critiques of this bill describing it as the "worst of both world. It was an inadequate benefit financed by cuts in Medicare" (Conan 2003), a veteran political reporter, Julie Rovner, observed "I've been here 20 years. I have never seen a vote stay open for three hours before" (Inskeep 2003). Ron Elving, Senior Washington Editor for National Public Radio, described the longest vote in the history of the United States House of Representatives as follows: "...Well, they started voting on it in the dead of night, and that was not entirely by accident. It was the culmination of their program before they were to leave for the rest of the year, and this was the last thing they wanted to do. They had more or less gotten their other ducks in a row. There are some appropriations matters hanging prior, but this was the last big thing. And they did not get to it until late on Friday night. But I think there was also a sense that it was going to be a tough vote, they were going to need to do a lot of last-minute, shall we say, heavy lobbying, some of which takes place at a high volume of voice. And they did not particularly want to have all the world watching. So they thought 3:00 would probably not be a bad time. Now they, of course, would have liked to have finished after 15 minutes, but it took three hours, and it was quite a scene (Conan 2003). This story continues to demonstrate more and more features of gaming the system as a Department of Health and Human Services inquiry revealed that Thomas Scully threatened to fire Medicare's top actuary, Richard Foster, if he revealed an accurate estimate of the new Medicare legislation's costs to Congress (Pear 2004a).

309. One such defender is FDA Commissioner Mark McClellan as this response to Bob Edwards's question indicates:  
 Edwards: "You just mentioned claims made by manufacturers of medicines and drugs compared to what they can actually do. Is advertising out of control? Are people taking drugs they don't need or shouldn't take?"  
 Dr. McClellan: "What we found for prescription drugs is that the advertisements do often get people into the doctor for a variety of infections, diabetes, depression, high blood pressure. And often, at least half the time, they don't end up getting the treatment that the advertisement was promoting. They end up getting a different treatment from their doctor that's more appropriate for their condition. At the same time, though, we've seen a lot of concerns from doctors, especially that people may not be getting an accurate picture of the risks and benefits of the products that are advertised" (Edwards 2003c).
310. Examples of well-known journalists that have been hired for this line blurring are Walter Cronkite, formerly of CBS News, and Aaron Brown of CNN. Morley Safer of CBS has also appeared in hundreds of these videos but has concluded this work as it "does not meet the standards of CBS News." In addition to the use of celebrity journalist to buy credibility that might not be warranted, another concern is that some companies make product claims that are unsupported by scientific evidence. Pharmacia, which has since been merged with Pfizer, paid for a video from Healthology that made the claim that the cox-2 inhibitor, Celebrex, could be used to treat lung cancer, which is a use that has not been approved by the FDA (Petersen 2003).
311. A modern example of self-serving behavior that contradicts neoliberal ideology was the imposition of steel tariffs by the United States in 2002. This measure to protect domestic steel was ruled "inconsistent" with free trade agreements by the World Trade Organization. The director of a trade group, UK Steel, described a rejection of the World Trade Organization's final ruling by the United States as "it looks to us as if the US is preparing to cheat on its obligations" (Osborn and Gow 2003).
312. The official representatives of the pharmaceutical industry that testified were Dr. R. Gordon Douglas, president of Merck Vaccine Division, David Williams, president of Connaught Laboratories, Dr. Ronald Saldarini, president of Lederle-Praxis Biologicals, and Jean-Pierre Garnier, president of North American Pharmaceuticals, SmithKline Beecham.
313. In a press release to "business editors" *Business Wire* publicized an "expert health care expert series" that "takes a critical look at the Canadian healthcare system and seriously questions those who are trying to bring Canadian-type reforms to the United States." Sally Pipes, "a Canadian currently living in California" explains that "Canada's system is based on a premise that prescription drugs are not necessary and Canadians get bargain rates because they're getting a free ride off the U.S. system" (Business Wire 2003). A web search reveals that Sally Pipes is the president and CEO of the Pacific Research Institute in San Francisco. Founded in 1979, the "mission of the Pacific Research Institute (PRI) is to champion freedom, opportunity, and personal responsibility for all individuals by advancing free-market policy solutions." The two celebrity endorsements on their website include:



Milton Friedman: "PRI is one of the most innovative and effective think tanks in the world."

Margaret Thatcher: "This Institute has done so much to further the idea of a law-governed liberty."

Accessed December 11, 2003

<http://www.pacificresearch.org/about/index.html>

314. In a press release to "news editors" *Canada NewsWire* publicized a study, *Canadian Prescriptions for American Patients*, by the Fraser Institute. "Prices for brand-name prescription drugs are lower in Canada because of its weak currency and lower standard of living than south of the border. As well, government drug benefit plans in Canada are able to free ride on research and development expenditures that are primarily borne by American patients," according to John Graham, author of this study and the Fraser Institute's director of health and pharmaceutical policy research (Canada NewsWire 2003). The Fraser Institute was founded in 1974 as a "federally chartered non-profit organization." Their head office is in Vancouver but they also list contact information for offices in Toronto and Calgary. Senior Fellows include former Conservative Premier of Ontario, Michael Harris, and founder of the Reform Party, Preston Manning. The Fraser Institute's mission statement is as follows: "The Fraser Institute is an independent Canadian economic and social research and educational organization. It has as its objective the redirection of public attention to the role of competitive markets in providing for the well-being of Canadians. Where markets work, the Institute's interest lies in trying to discover prospects for improvement. Where markets do not work, its interest lies in finding the reasons. Where competitive markets have been replaced by government control, the interest of the Institute lies in documenting objectively the nature of the improvement or deterioration resulting from government intervention." The 47 members of the Board of Trustees of the Fraser Institute includes C. Windels of Pfizer Inc., New York Accessed December 11, 2003  
<http://www.fraserinstitute.ca/>
315. Physicians who testified included Dr. Dean Sienko, Ingham County Health Department, representing the National Association of County Health Officials, Dr. David Smith, Texas Department of Health, representing the Association of State and Territorial Health Officers, Dr. Ed Thompson, Mississippi Department of Health, representing Council of State and Territorial Epidemiologists, and Ed Marcuse, Washington chapter of American Academy of Pediatrics (*Comprehensive Child Immunization Act of 1993*).
316. This statement by Dr. Mark McClellan was aired on National Public Radio during an interview on September 12, 2003 (Flatow).
317. A transcript of the interview between FDA Commissioner, Dr. Mark McClellan, and Ira Flatow on National Public Radio reveals that there seems to be different standards of rigor in acknowledging Wild West traits when comparing FDA rigor concerning counterfeit drugs and consumer protection through fool labeling. In a long exchange a caller, "Ann Marie," identified herself as the mother of a child with life-threatening food allergies and pressed Dr. McClellan hard on misleading food labels. Ann Marie asked, "But how can they put non-dairy in bold print on the front of a product and yet have a dairy ingredient listed on the back?" Instead of admitting that food manufacturers were engaging

in Wild West marketing practices that have sent people into anaphylactic shock, Dr. McClellan hedged about conflicting lines of responsibility between the FDA and the Department of Agriculture and ultimately put the responsibility back onto individuals. McClellan's ultimate stance was "parents like you who have kids with serious allergies need to be vigilant" (Flatow 2003).

318. The Pharmaceutical Research and Manufacturers of America (PhRMA) "represents the country's leading pharmaceutical research and biotechnology companies, which are devoted to inventing medicines that allow patients to live longer, healthier, and more productive lives. The industry invested an estimated \$32 billion in 2002 in discovering and developing new medicines. PhRMA companies are leading the way in the search for new cures and treatments." The tag line on their website is "New Medicines, New Hope." Accessed December 11, 2003 <http://www.phrma.org/>
319. Additional FDA testimony may be found in (2003).
320. The pharmaceutical industry has 623 registered lobbyists in Washington, D.C., which outnumbers the 535 members of the United States Senate and House of Representatives. Pfizer alone employs 82 lobbyists (Olive 2003).
321. Pfizer has been described as the industry's "first superpower" with its largest line of "blockbuster drugs" that generate at least \$1 billion a year in sales (such as Viagra, Zoloft, and Lipitor). "With 2002 sales of \$52.2 billion (U.S.), Pfizer is more than 40 per cent larger than its closest competitor, Johnson & Johnson Inc. After its stunning \$150 billion takeover spree of the past three years in which it acquired rivals Warner-Lambert Co. and Pharmacia Corp. Pfizer now holds the marketing rights to eight of the world's top 25 best-selling drugs" (Olive 2003).
322. For a different perspective from the pharmaceutical industry, we could turn to Europe. "William Burns, chief of Roche Holdings pharmaceutical group, told analysts this month that Europe's long experience with imports across borders indicated that such trade need not be worrisome. 'When we look at it from our window in Europe,' he said, 'it's rather difficult to see how it can be justified to prevent within the North American free trade area certain movements of product' (Harris 2003).
323. Marcel Cote is a former adviser to both Prime Minister Brian Mulroney and Quebec Premier Robert Bourassa (Thompson 2003).
324. Side effects of protease inhibitors, for example, are often brutal. One brave and funny person taking ritonavir described these symptoms: "I had lots of diarrhea. My skin was sensitive; it hurt to comb my hair, and the elastic on my underwear hurt. Sometimes I would get a bit dizzy and disorientated. My lips and mouth went numb, and I almost completely lost my sense of taste." He added wryly, "I redid the entire apartment in shag carpeting" (Schoofs 1996).
325. The head of the Canadian International Pharmacy Association, Andy Troszok, estimates the number of physicians who regularly co-sign cross border prescriptions to be in the "low hundred" dispensing as many as 2 million prescriptions per year. "Mr. Troszok said the doctors tend to approach the pharmacies themselves for work and often feel they have a moral duty to help

poor Americans obtain more reasonably priced medicine. They say, 'I don't feel uncomfortable. I think this is a good service. And if I can get paid for this, and provide a good ethical service, I have no problem with it.' Fees are reported as high as \$15 per prescription" (Blackwell 2003).

326. Julie Rovner explains that physicians had "a Medicare problem" in that doctors were facing a 4.4% cut in payments starting in January 2001 just two years after absorbing a 5.4% cut. The Medicare bill changes the prospective cut into a 1.5% increase. The president of the American Medical Association, Donald Palmisano, said this averted an "access-to-care problem." Rovner translates this code: "in other words, more doctors might have had to stop taking new Medicare patients, or worse, drop existing ones." Palmisano further states: "Physicians and other health professionals are the foundation of Medicare. If you don't have a physician to start the treatment it doesn't matter if you have a prescription drug benefit or everyone has health insurance"(Edwards 2003b).
327. Joanne Silberner explains: "Right now Medicare gives doctors slightly less than the average wholesale price for the drugs they administer, yet according to a study by the General Accounting Office doctors regularly get a deep discount for cancer drugs. For one product, they pay 86% less than the average wholesale price, and they pocket the difference" (Silberner 2003).
328. Alan Sager, PhD and Deborah Socolar, MPH are directors of the Health Reform Program at Boston University School of Public Health. The cited report is available from:  
<http://www.healthreformprogram.org/>
329. In another example of a public relations kind of "grassroots coalition" the drug industry funded Citizens for Better Medicare. As of September 2000 this group had spent \$38 million on the 2000 campaign which was more than any organization outside of the Republican and Democratic parties (Hamburger 2000). Citizens for Better Medicare were spending more than one million dollars per week on issue ads. One television ad featured "a perky senior named 'Flo' who complained about a government-run prescription-drug plan, saying 'I don't want big government in my medicine cabinet'" (Hamburger 2000).
330. As the administrator for the Centers for Medicare and Medicaid Services Thomas A. Scully was intimately involved in drafting Medicare legislation. He has become "the object of a bidding war" among five firms who seek to hire his intimate knowledge of the federal programs and the implications of the new legislation. The five firms and selected health industry clients are as follows:
  - **Alston & Bird:** represents the National Association for Home Care and Johnson & Johnson, among other clients.
  - **Baker, Donelson, Bearman:** represents the Disease Management Association of American, "which scored a major victory in the Medicare bill, authorizing payment for services provided by its members to people with chronic diseases." Other clients include the American Association for Homecare, Amgen, and the Federation of American Hospitals.
  - **Ropes & Gray:** represents the Pharmaceutical Research and Manufacturers of America, with its interest in changes in patent drug laws described as "one of the hottest issues in the Medicare bill." This firm also represents many drug

companies including Abbott Laboratories, AstraZeneca, BristolMyersSquibb, Eli Lilly, Novartis, and Pfizer.

- **Welsh, Carson, Anderson & Stowe:** a private equity firm with many health care businesses. These include a “major stake in U.S. Oncology, which manages cancer treatment centers and lobbied for more adequate payments under the Medicare bill.”
- **Texas Pacific Group:** this private investment group manages assets in excess of \$13 billion. “It helped rescue Oxford Health Plans, which suffered severe financial problems while Mr. Scully was a member of Oxford’s board.”

Preceding data and quotations are from (Pear 2003b). On December 18, 2003 it was reported that Scully would join former Senator Bob Dole and another recently hired top Senate Finance Committee staff member who had worked on the Medicare legislation at Alston & Bird’s health care group. Ben Johnson, managing partner for the law firm, said that “he expects Scully will interpret the new Medicare law for the firm’s clients. ‘I don’t think that I envision him doing lobbying any more than I envision Bob Dole doing lobbying,’ Johnson said. ‘What they can do is explain to clients what the political and regulatory landscape looks like, how people ought to adapt the way they do business to fit into the new landscape’” (Associated Press 2003b).

331. AARP chief executive William Novelli says, “Boomers are the future of AARP.” This organization that started 45 years ago has shed the term “retired” from its name and has reduced its membership age from 55 to 50 years. Its glossy magazine is pitched to a target audience that appreciates Lauren Hutton as the cover girl and stories about “where to find love” and “amazing new sex drugs” (Stolberg and Freudenheim 2003).
332. Hawaii’s Willie Sutton pleaded guilty to putting a counterfeiting trademark stamp on pills that he sold as Viagra for about five years. Seon II Kim was charged with money-laundering for transmitting \$5,200 from his Viagra business to Greatide Industrial Co. in China in order to purchase sildenafil citrate. Kim manufactured the pills in his Waikiki apartment, where he used three pill presses to imprint the Pfizer drug logo, and then he sold his product to tourists for \$300 per bottle. Kim could be fined up to \$2 million and imprisoned for 10 years on the counterfeiting charges and faces a possible 20 years imprisonment for the money laundering charges (Apgar 2003). Another way to look at this purported money laundering is that he was engaging in free trade hampered by an overly restrictive regulatory environment that required unreasonable paperwork for a recreational product. Counterfeiting could be viewed as both a celebration of the vibrancy of the entrepreneurial ethos and/or a civil rights action resisting the validity of intellectual property rights by transgressing proprietary conventions. Framed as a demonstration of microenterprise, maybe Kim could have gotten a seed grant as a community development project. With a Pfizer’s public relations team in situ, perhaps Kim could have been nominated for his humanitarian and health promotion work. Why should Kim selling the same ingredients for a lower price be criminalized? A quick scan of mainstream news does not challenge a “because that’s where the money is” reading of this event.
333. To take but one example in the United States, there are nearly 4,000 new cases of HIV disease occurring in the United States each year and people are living longer because of more effective medications. “More than half of the people with AIDS in the US are covered by Medicaid, a federal and state program of matching

grants. Eligibility is now being limited to the poorest because of budget crises in most states. Another third is covered by the Ryan White CARE Act and the AIDS Drug Assistance Program that already has a shortfall of \$80 million halfway into the fiscal year....Right now 16 programs across the country have put restrictions on it, either by lowering eligibility or reducing the drugs that are covered. And 13 of these have closed enrollment to new people. Right now there are close to 700 people who are on the waiting lists across the country. In two states so far, West Virginia and Kentucky, there have been reports of people with AIDS who died while on waiting lists for medications" (Edwards 2003a).

334. "Fundamental double bind" is from Deane Neubauer, personal communication, October 14, 2003.
335. "In the free trade talks, drug industry executives said, the United States is asking that Australia agree that its Pharmaceutical Benefits System pay higher prices for new medicines and make other changes in how it sets the price of prescription drugs. 'This is all going on in this larger context of growing unrest in the United States that other countries are not paying their share of the cost of pharmaceutical research,' said Ian Spatz, vice president for public policy at Merck & Company" (Becker 2003).
336. Peter Kramer addresses the kind of individuality that is rewarded. Historically, social critics believed that "industrial capitalist society instilled and rewarded the 'anal character,' a style marked by dampened enthusiasms, compulsive control, and conformist rigidity. The success of Prozac says that today's high-tech capitalism values a very different temperament. Confidence, flexibility, quickness, and energy—the positive aspects of hyperthymia—are at a premium" (Kramer 1993: 297).
337. These two points are among six "simple truths" identified by (Lewis, Saulnier, and Renaud 2000: 510-512): health systems want to grow; higher health spending does not necessarily lead to higher health status; universal access to health care does not lead to universal good health; public awareness of risks to health has greatly improved; health care almost always wins out in competition for resources; and changing the distribution of health status through 'upstream' strategies is extraordinarily difficult.
338. A helpful discussion on the social construction of crisis in health discourse may be found in (Neubauer 1982, 1994).
339. Examples of national "health care reform" discourse in postindustrial countries other than Canada and the United States include the following: Australia (Podger and Hagan 1999), Britain (Paton 1997), Germany (Altenstetter 1997), Netherlands (Bjorkman and Okma 1997) and Sweden (Diderichsen 1995). "Developing countries" are also not spared the "epidemic" of health care reform as may be evinced by market reforms strategies propagated in the *World Development Report 1993: Investing in Health* (World Bank) and "making health development sustainable" themed conferences (Berman 1995).
340. Janice Gross Stein describes a cult as "a system of religious worship that engenders almost blind loyalty in its members" (2002: 4). Her book, *The Cult of*

*Efficiency*, examines the rhetoric of efficiency as a tool to promote market-based reform agendas in health care and education in Canada.

341. (Oeppen and Vaupel 2002) point out the public policy and political implications of their analysis as follows: "Continuing belief in imminent limits is distorting public and private decision-making. Forecasts of the expectation of life are used to determine future pension, health-care, and other social needs. Increases in life expectancy of a few years can produce large changes in the numbers of the old and very old, substantially augmenting these needs. The officials responsible for making projections have recalcitrantly assumed that life expectancy will increase slowly and not much further. The official forecasts distort people's decisions about how much to save and when to retire. They give politicians license to postpone painful adjustments to social-security and medical-care systems." This "Broken Limits to Life Expectancy" article in *Science* was reported in *The Guardian* with the following headline: "Health Crisis Looms as Life Expectancy Soars" (Meek 2002).
342. The argument here is as follows: "If nothing is done quickly to extend working lives, living standards will fall in the course of the coming decades. We know, because of the ageing of our populations, that there will be fewer and fewer persons of working age to support more and more older people. For the OECD as a whole, the dependence ratio of older people (i.e. those aged 65 and over as a proportion of those aged 20-64) will rise from the current figure of 22%, to 46% in 2050. In these circumstances, it is essential to have as many people working as possible - young people, women and especially older workers (OECD 2004).
343. (Evans, McGrail et al. 2001: 161) attribute the descriptive phrase "apocalyptic demography" to (Gee and Gutman 2000).
344. In contrast to this view, James Fries theorized an opposite scenario where a fixed lifespan and a falling need for health care (because people were healthier or undergoing a "natural death") would result in less medical services (Evans, McGrail et al. 2001: 165). An analysis of trends of medical care utilization in British Columbia demonstrate minimal effects of population aging (Evans, McGrail et al. 2001: 176).
345. Proponents of maintaining the health insurance status quo in the United States and advocates of private medical care funding and delivery in Canada (Hogan and Hogan 2002: 15) strategically frame aging populations as the primary driver of "unsustainable" health systems costs.
346. Scholars that are skeptical of "overselling" aging populations include (Buser 2002: 55-56), (Evans, McGrail et al. 2001), (Docteur and Oxley 2003: 74), and (Gee and Gutman 2000).
347. For the past twenty years the pattern in the United States for all persons aged 65 years of age or more in the Medicare program is as follows: "It shows that five years before the year of death, the annual health cost is virtually the same as all annual Medicare costs per capita. By the second year before death the cost rises by about 60%, and in the year of death the annual cost is four times the average cost. Indeed, expenditure on persons during their last two years of life account for 40% of all Medicare expenditures" (Fogel 2002: 34). Studies in different

countries have confirmed that younger decedents and those with less impairment in the activities of daily living tend to have higher medical expenditures as “money is spent on the patients who are likely to benefit most” (Jacobzone 2002: 44).

348. Health Canada is the federal ministry in Canada equivalent to the Department of Health and Human Services in the United States. In addition to population aging, the other factors identified as drivers of health care spending by Health Canada in their testimony to the Kirby Commission are: fiscal capacity; technology and innovation; factors affecting need and demand for health services (including population health status, preference, and values); changes in the structure of health care delivery systems; and relative costs of health care compared to general price inflation (Kirby 2002b: 11).
349. A broad definition of health care technology used by the Kirby Commission is “the set of techniques, drugs, equipment, and procedures used by health care professionals in delivering medical care to individuals and the systems within which such care is delivered” (Kirby 2002b: 37).
350. Art Stewart, for example, writes “countries that have been relatively successful in cost containment have some measure of control over the diffusion of medical technology” (1999: 73).
351. Evans et al. use Lewis Thomas’s classification of medical technologies as an illustration of technology’s cost being dependent on its stage of development. “First stage technologies are based on little or no understanding, and are consequently palliative, cheap, and mostly ineffective. Second stage or half-way technologies are based on sufficient understanding to relieve some of the symptoms of an illness or injury, and are semi-effective and quite expensive. Mature third stage technologies are based on full understanding, permit decisive interventions to “cure” the disease, and are again relatively inexpensive. The treatment of polio, with the development of the iron lung and then the vaccine, is illustrative of the second and third stages” (2001: 164-165).
352. Although posited by some authors as “the primary driver of health-care spending,” a meta-analysis by the OECD states that “there is little firm evidence concerning the role of technological change” because of “its trend nature and the absence of appropriate proxy variables” (Docteur and Oxley 2003: 74). Modeling and extrapolation of the role of technology once other variables have been removed are presented as arguments for technology being cost increasing rather cost decreasing for several health economists (Docteur and Oxley 2003: 74). Literature reviews and expert testimony to the Kirby Commission in Canada resulted in the following conclusion: “In general, a technology can be: 1) *more* effective and *more* expensive; 2) *more* effective and *less* expensive; 3) *less* effective and *less* expensive; 4) *less* effective and *more* expensive. Unfortunately, however, the Committee was told that the precise contribution of technology to the costs of health care in Canada is not known. Attempts to quantify the connection between technology and rising health care expenditures has suffered from a lack of reliable data. The majority of studies to date have treated technology as a “residual” item, attributing to technology that portion of the increase in health care spending not accounted for by more easily identifiable factors” (Kirby 2002b: 43).

353. Stefan Timmermans's study of the use of cardiopulmonary resuscitation in sudden death situations outside of hospitals is an example. He juxtaposes a 1-3% survival rate of people discharged from hospital after out-of-hospital cardiac arrests and the trauma of heroic interventions detached from other considerations with an unexamined "resuscitation ethic" that infuses popular and medical culture (1999: 4).
354. Practice variations differ among countries (cardiac catheterization: USA 6.4 units per million persons; Germany 3.4 units per million persons; Canada 2.8 units per million persons (Kindig 1997: 31), among geographical regions within countries (see for example, classic work by Wennberg demonstrating in Maine that the probability that a woman would have a hysterectomy was 20% in some markets and 70% in others) (Office of Technology Assessment 1994: 208), and between physicians in different specialties. See, for example, differences among psychiatrists, endocrinologists, and surgeons in diagnosis and treatment approaches to gender dysphoria (Hirschauer 1998) and intersexed infants (Kessler 1990).
355. Examples in the category of devices, equipment and supplies include computed tomography (CT) scans, magnetic resonance imagers (MRIs), cardiac pacemakers, surgical gloves, and diagnostic test kits (Kirby 2002b: 37).
356. Examples of medical and surgical techniques from Kirby include coronary angiography and gall bladder removal (2002b: 37).
357. Support systems include clinical laboratories, telemedicine, blood banks, and electronic patient record systems (Kirby 2002b: 37).
358. Kirby illustrates ideas with the examples of washing hands between patients and early ambulation after surgery (2002b: 37).
359. A pap smear test would be an example of a procedure (Kirby 2002b: 37).
360. Handwashing by health care workers is yet another human arena where there is only a modest correlation between reported and observed behavior (Larson et al. 1986). One small study of 22 health care personnel working in an oncology unit found that physicians washed significantly less often, but more thoroughly, than nurses (Larson et al. 1986). In this study both doctors and nurses were equally contaminated when hand cultures were done, with coagulase-negative staphylococci resistant to antimicrobial agents being of particular concern (Larson et al. 1986). Physicians were found to be more "non-compliant" with handwashing than other health care personnel in settings such a teaching hospital in Switzerland (Pittet et al. 1999), pediatric intensive care unit (Donowitz 1987), and urban emergency room (Dorsey, Cydulka, and Emerman 1996). The overall average compliance with hand hygiene has ranged from 16% to 81% in various settings in studies published from 1981 to 1999 (Pittet 2001: 234). The largest hospital-wide survey found average handwashing compliance at 48% with noncompliance increasing in higher risk situation for bacterial contamination in the intensive care unit (Pittet et al. 1999: 127). The gap between theory and practice remains topical as in the February 2004 editorial in *Critical Care Medicine* entitled "Do As We Say, Not As We Do: Healthcare Workers and



Hand Hygiene" (Arroliga, Budev, and Gordon 2004). The Joint Commission on Accreditation of Healthcare Organizations points out the large discrepancy between the small number of infection-related sentinel event cases reported to their organization with Centers for Diseases Control estimates of approximately 90,000 patients who die each year from hospital acquired infections (JCAHO 2003).

361. In order to highlight the blurring of the line between organic and inorganic material, Richard Oliver uses the term "bioterials" as a blending of technology and materials (Oliver 2003b: 19). He argues that technology creates economic eras, which he outlines as the Agrarian Age (6,000 BCE to 1760 CE), Industrial Age (1760-1950), Information Age (1950-2000), and Bioterials Age (2000-2025 or 2000-2030). For Oliver, bioterials "are the new engine of the economy" (2003b: 14-15).
362. Genomics includes all genetic information integrated in a cell in a given species (Ho and Gibaldi 2003: 430). The structure and function of various DNA sequences are studied in order to discover linkages between genes and particular disease states or medications. It is estimated that there are around 25,000-30,000 unique human gene transcripts which is equivalent in complexity to "roughly a fly plus a worm or the equivalent of a plant" (Ho and Gibaldi 2003: 431).
363. Predicting future health status by genetic testing is both a source of concern as a new basis for discrimination and "medicine's new gold mine." Mining massive data bases to discover and patent tests for genotypes correlated with illness is portrayed as lucrative even as the risks and benefits are debated (Morgan and Hurley 2002: 5).
364. Pharmacogenomics involves "screening of patients for genes that predict the capacity to benefit from or be harmed by pharmaceuticals" (Morgan and Hurley 2002: 6).
365. "So venture capitalists, not wanting to wait 10 years or more for a return on their investments, are backing companies that can move products to market faster. That often means developing a drug neglected by another company or finding a new use for or a new way of delivering an existing drug. The industry buzzwords are no longer "monoclonal antibodies" and "genomics" but "reformulate" and "repurpose" (Pollack 2004).
366. Lewis Thomas first wrote about the "cost of worry" in 1977: "Nothing has changed so much in the health-care system over the past twenty-five years as the public's perception of its own health. The change amounts to a loss of confidence in the human form. The general belief these days seems to be that the body is fundamentally flawed, subject to disintegration at any moment, always on the verge of mortal disease, always in need of continual monitoring and support by health-care professionals. This is a new phenomenon in our society" (1988: 311-312).
367. John Knowles included screening for risk-factors that are linked to disease as part of preventive measures but it clear where he situated the main responsibility for health in an article originally published in 1977: "The cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy, and smoking is now a

national, and not an individual freedom—but one man’s freedom in health is another man’s shackle in taxes and insurance premiums. I believe the idea of a “right” to health should be replaced by the idea of an individual moral obligation to preserve’s own health—a public duty if you will” (Knowles 1994: 371-372).

368. An excerpt from a Canadian newspaper, *The National Post*, illustrates some of the ambivalence associated with pre-hypertension labeling: “Canadians over the age of 55 have a 40% chance of having hypertension, and a 90% chance of developing it once they are in their 60s, the World Health Organization reported last October. Because the risk is so high, some Canadian experts believe the new pre-hypertension classification will only serve to label people who will probably develop it anyway -- if they don't already have it. “It would be a medicalization of most of our population,” said Dr. Norm Campbell, a spokesman for the Heart and Stroke Foundation. “Some people don't like being labeled.” Dr. Campbell cited an earlier study that found when people with normal blood pressure are told they have hypertension, they perceive symptoms that aren't present. “Labeling may not be benign, and it may mean that people are going to be seeing more doctors.... That's a good thing, if they actually end up doing something about it, but it is fairly resource-intensive in a setting where we have a national health system” (Poole 2003).
369. Discussion of factors underlying “the infinite demand for health” may be found in (Neubauer 1992).
370. This phrase is from the poem “Do Not Go Gentle Into That Good Night” by Dylan Thomas (1914-1953) that begins:  
Do not go gentle into that good night,  
Old age should burn and rage at close of day;  
Rage, rage against the dying of the light.
371. An editorial in the *Canadian Medical Association Journal* raises the provocative question: “Abuse of Emergency Department Workers: An Inherent Career Risk or a Barometer of the Evolving Health Care System?” Part of this discussion is as follows: “The emergency department has become the safety net in the system. When the emergency department cannot fulfill expectations and desires, patients and others direct their anger toward those immediately available. The perceived needs of the patient may be legitimate or excessive. Unjustified demands may be fuelled by the political and media focus on the scenario of decreasing quality of health care, which contributes to a “learned” expectation of compromised care and access. In addition, a well-informed public believes that technology is the only way to be sure that the doctor has made the correct diagnosis, and so it demands access to technology and specialty consultation, putting unnecessary stress on the system. The perception that government cutbacks have limited access to specialists and subspecialties leads some people to present to the emergency department, particularly in urban and academic settings, to expedite consultations and gain access to advanced technology. Unfortunately, some physicians advise their patients to present to the emergency department to obtain access to these resources, thus reinforcing this perception” (Morrison 1999: 1263).
372. “The culture of prescribing” is from (Butler et al. 1998). This qualitative study conducted in Wales demonstrated some of the complex interpersonal factors that

are intrinsic to prescribing decisions in settings where direct to consumer advertising is not legal. Although doctors in this study knew that antibiotics were not helpful for most people with a sore throat, they were reluctant to jeopardize their relationships with patients over their use. A similar study in England concluded that patients' beliefs "that infection is the problem and antibiotics the answer" influenced physicians to prescribe antibiotics for lower respiratory tract illness for three-quarters of patients in this study even though the general practitioners thought antibiotics were definitely indicated in only a fifth of the cases (MacFarlane et al. 1997: 1211). More recent research suggests that the dynamics may be even more complex in that sometimes perceived pressure from patients may be stronger in the physicians' mind than in the patients (Britten 2004).

373. "Technical quality refers to the impact of the health services on the health conditions of a particular population. Technical quality is an important dimension of providers' performance. Sociocultural quality measures the degree of acceptability of services and responsiveness to users' expectations. The road toward improving quality is full of human resources challenges, in view of the complexity of the interface between users and providers. Constraints posed by budget cuts and the lack of congruence between the reforms' and the workers' values, translate in changes in performance levels and in users' satisfaction" (Rigoli and Dussault 2003: 3).
374. The *World Health Report 2000* generated a host of controversies. This brief discussion can only suggest the complexity of this topic by mentioning that some of the scholars most well known for their research into health inequities were highly critical of the report's methodology for undercutting its stated aims. "Because the *World Health Report 2000* does not measure differences in health between different social groups, it effectively removes equity and human rights from the public health monitoring agenda. For example, there are no data to determine whether progress is being made in closing gaps in nutritional status between children in poor and non-poor families, whether racial or ethnic disparities in infant mortality are being reduced, or whether the large sex gaps in child mortality and immunization rates in many countries are being narrowed" (Braveman, Starfield, and Geiger 2001: 679). This critique was disparaged by an author affiliated with the World Health Organization by arguing for a more "comprehensive" approach which does not run "the risk of discouraging scientific inquiry into the causes of inequality" (Murray 2001: 680). Other criticisms of the *World Health Report 2000* include concerns about its "political biases, its methods and indicators, and its lack of reliable data" as well as usefulness for policy makers and flaws with process as member states and governing bodies of the WHO were not consulted during the production of the report (Ollila and Koivusalo 2002: 503).
375. Institute of Medicine, *Crossing the Quality Chasm*, accessed March 14, 2004 <http://www.iom.edu/focuson.asp?id=8089>
376. The fourth leading cause of death assumes a 10% attack rate with 30% attributable mortality (105,500 annual deaths) while thirteenth leading cause of death assumes a 2.5% attack rate with 10% mortality (8,750 annual deaths) (Wenzel and Edmond 2001).

377. Representative academic literature that outlines evolving recognition of the significance of disparities for health of individuals and communities includes the following: International health divide (Evans, Whitehead et al. 2001); Developmental growth and development (Keating and Hertzman 1999; Shonkoff and Philips 2000); Poverty and Income Inequality (Wilkinson 1996; Kawachi, Kennedy, and Wilkinson 1999; Berkman and Kawachi 2000; Leon and Walt 2001; Tarlov and St. Peter 2000).
378. For Australia, see for example (McClelland 1991), (Hupalo and Herden 1999), and the Health Inequalities Research Collaboration website at <http://www.hirc.health.gov.au/>
379. For New Zealand, see (Tobias and Howden-Chapman 2000) and (Ministry of Health 2000) available from [www.moh.govt.nz/publications/nzhs](http://www.moh.govt.nz/publications/nzhs)
380. The twin goals associated with this White Paper are “to improve health and to reduce the health gap (health inequalities). The strategy aims to prevent up to 300,000 untimely and unnecessary deaths by the year 2010.” Specific targets (life expectancy and infant mortality) as well as an action plan may be found on the “Our Healthier Nation” website. Website accessed May 1, 2004 <http://www.ohn.gov.uk/ohn/ohn.htm> It is also interesting to note that cross-disciplinary scholarship on equity in health and health care is between fostered in this environment. See for example (Oliver 2003a). Collaborative efforts are also being made in formulating a “local basket of indicators” in order “to help support local action to achieve the Government’s national inequalities targets for life expectancy and infant mortality” (Fitzpatrick and Jaccobson 2003: 2).
381. While aggregate data is useful for giving a snapshot of a situation, further breakdowns using different data sources highlight the magnitude of the discrepancies in life expectancies even further. The differences for life expectancy in Australia become a full 21 years for men and 20 years for women. The discrepancy for Inuit women is especially significance when the data is broken down showing 14 years difference. Researchers also advise that “life expectancy at birth for Nunavut should be interpreted with caution due to a small underlying count” (Canadian Institute for Health Information 2004b: 101). Data on life expectancy at birth by race/ethnicity that is available from the State of Hawaii (<http://www.hawaii.gov/dbedt/>) on April 26, 2004 is limited to Table 2.10, which combines data for both sexes for years 1910 to 1990. The life expectancy for both sexes, all races, for the state of Hawaii in 1990 was 78.85 years. Hawaiians/ part-Hawaiians had the lowest life expectancy at 74.27 years, while the highest life expectancies were recorded as Japanese at 82.06 and Chinese at 82.93 years (DBEDT 2004). This sanguine estimate, based the Hawaii Health Survey as modified by the Cancer Research Center, may be contrasted with estimates based on population data from the U.S. Census reproduced on the Office of Hawaiian Affairs website. Life expectancy for both sexes combined for 1990 for native Hawaiians was estimated to be 67.95 years, while Japanese were 82.17 and Chinese were 83.38 years (OHA 1996: Table 6.44). Disaggregating statistics as in Table 6.10 is useful for demonstrating the gap between the lowest and highest life expectancies in the state of Hawaii for 1990: there is a 14.76 year difference between Chinese and Hawaiian women and 15.93 year difference for men of those respective groupings. It is also noteworthy that life expectancy data for native Americans/ Alaskan Indians is not readily available. Table 27 of the

*Health, United States, 2003* shows life expectancy at birth for all races, white, and black/ African American but not for indigenous people (Freid et al. 2003: 133). A Department of Health and Human Services publication on health disparities conflates peoples and genders together to summarize for “today” using state data: “American Indians and Alaska Natives born today have a life expectancy that is almost 6 years less than the U.S. all races population (70.6 years to 76.5 years, respectively; 1996-1998 rates) (Indian Health Service 2002: 1).

**Table 6.10 Disaggregate Life Expectancies, Australia, Canada, New Zealand, and State of Hawaii**

	Female Life Expectancy at Birth (years)	Male Life Expectancy at Birth (years)
Australia (2002)	83	77
Aboriginal	63	56
Canada (1999)	82	76
First Nation	77	69
Inuit	68	70
New Zealand (2002-2002)	81.1	76.3
Maori	73.2	69
State of Hawaii (1990)		
Hawaiians	71.55	64.58
Chinese	86.31	80.51

Data sources: Australian data is from Australia Social Trends 2002, Health—Mortality and Morbidity: Mortality of Aboriginal and Torres Strait Islander People, Australia Bureau of Statistics, updated June 2, 2003, Accessed April 24, 2004 <http://www.abs.gov.au/Ausstats/> Canadian data is from (Canadian Institute for Health Information 2004b: 81), New Zealand data is from Table 1, New Zealand Life Tables 2000-2002, Statistics New Zealand, accessed April 24, 2004 <http://www.stats.govt.nz/> State of Hawaii data is using U.S. Census estimates from the Office of Hawaiian Affairs (1996: Table 6.44).

382. Disaggregation of this data shows further important information. The infant mortality rate per 1,000 live births for Canada was 5.3 but 8.0 for First Nations, and 15 for Inuit (Canadian Institute for Health Information 2004b: 81). At the same time, researchers suggest that “infant mortality rate for Nunavut should be interpreted with caution due to a small underlying count” (Canadian Institute for Health Information 2004b: 101).
383. The percentage of aboriginal Canadians with diabetes is listed as “data not available” in (Papillon and Cosentino 2004: 25). Data from the Canadian Institute for Health Information, however, demonstrate diversity within the subset of aboriginal peoples of Canada with respect to prevalence of diabetes:

**Table 6.11 Prevalence of Diabetes, Aboriginal Groups and Non-Aboriginal, Canada**

Non-Aboriginal	4%
Aboriginal, non-reserve	9%
First Nations	11% male; 17% female

Inuit	2%
Métis	6%

These authors “note that many of these comparisons ideally require age adjustment for true comparability, since the age structures of the Aboriginal and Canadian/non-Aboriginal populations are different. Data for doing this, however, are not consistently available” (Canadian Institute for Health Information 2004b: 83).

384. President George W. Bush’s State of the Union address delivered on January 20, 2004 (<http://www.whitehouse.gov/news/releases/2004/01/20040120-7.html>) provides an example: “A government-run health care system is the wrong prescription. By keeping costs under control, expanding access, and helping more Americans afford coverage, we will preserve the system of private medicine that makes America’s health care the best in the world” (Bush 2004).
385. Although the claims of medicine tend to be triumphal as in the historical accounts of Le Fanu that were discussed in Chapter Two, John Bunker states “there are no population-based data to allow a direct estimate of the contributions of medical care to life extension or to the quality of life. In the absence of such data, my colleagues and I have created inventories of the outcome benefits of the preventive or curative care for individual conditions. Based on such an inventory of established life extending outcomes of preventive and curative services for individual conditions, I estimate that about half of the 71/2 years of increased life expectancy since 1950 can be attributed to medical care” (Bunker 2001: 1260).
386. A more elegant formulation is as follows: “One might argue that it is unreasonable to expect health care to fundamentally affect the distribution of health throughout society. After all, it deals with only a small fraction of the population at any given time, and usually comes into play after health problems have occurred. However, if the medical-industrial complex claimed only modest credit for improving population health status, formally recognized the preeminence of the socioeconomic, environmental, and other determinants of health, and otherwise acknowledged the limits of its impact, its ability to secure and retain an ever-increasing share of national wealth would be compromised” (Lewis, Saulnier, and Renaud 2000: 510-511).
387. For the importance of hospitals as “doctors’ workshops” see Paul Starr who argues that “for both economic and scientific reasons, the rise of hospitals was a key precondition for the formation of a sovereign profession” (1982: 72).
388. Bob McAuliffe, a patient recovering from a heart attack in Bronson Methodist Hospital in Kalamazoo Michigan, was featured in a story reporting a trend of “almost all new hospital rooms being built are single rooms.” The rate for one night of room and board at this hospital is \$1,459-- “a cost covered by Medicare, Medicaid and most private insurance plans because the hospital has only individual rates.” For this, patients get their own bathroom, less chance of nosocomial infections, more privacy to discuss issues with health care staff and other amenities: “The large window allowed in plenty of sunlight and provided a panoramic view of the outdoors. A chair near his bed could be converted into a sleeper for an overnight visitor, a special room service menu and an errand-running concierge were only a phone call away. ‘It’s airy, it’s light—it’s really

like a resort or a hotel,' the 64-year old retired sheet-met worker from Marshall said while surveying his surroundings from his bed" (Associated Press 2004b).

389. "Whether patients enter through the emergency room, the outpatient clinic, an adjoining medical office building, or the front door, a properly designed facility can serve them as a therapeutic device. These 'environments will help ease patient stress, reduce medication levels, and promote shorter hospital stays.' At Miami's Baptist Hospital, TRO/The Ritchie Organization reinvented the conventional emergency room by designing 'an interior courtyard that continues the Renaissance motifs of the exterior, with brick vaulted ceilings, tile pavers, columns, arches, soft pinks, yellows, and greens.' A large skylight shielded an overhanging oak contributes to a design that evokes the lobby of a hotel rather than the bloody and harried emergency room. And, the hospital's administration has committed to training its staff in 'guest relations'" (Sloane and Sloane 2003: 94-95).
390. "The 'medical mall' was pioneered in Texas in 1974 when Robert Wright opened Medical City Dallas. Medical City was a 1.56 million-square-foot medical and retail mixed development. The complex housed traditional medical facilities, such as emergency room, outpatient clinic, and inpatient hospital, as well as three medical office towers with 130 physicians' offices, a play area for children, two pharmacies, and 21 nonmedical businesses" (Sloane and Sloane 2003: 110). Thirty years later, mixed used medical office space has become "hot" so that properties on the main campus of Swedish Medical Center in Seattle are expected to sell for \$120 million. In 2003, "\$1.3 billion worth of medical office buildings individually valued at \$5 million or more changed hands...In one of the costliest deals in terms of price per square foot, Washington Real Estate Investment Trust, a public company in Rockville, Md., paid \$78 million, or \$312 a square foot, for the three medical buildings that make up the Prosperity Medical Center near Inova Fairfax Hospital in Falls Church, Va" (Pristin 2004).
391. "Current estimates of the incidence of medication errors are undoubtedly low because many errors go undocumented and unreported. For example, in a study of patients admitted to five patient care units at a tertiary care hospital during a six month period in 1993, it was found that incident reports were filed with the hospital's quality assurance program or called into the pharmacy hotline for only three of the 54 people experiencing an adverse drug event" (Institute of Medicine 2000: 34).
392. "The reasons for the decline in autopsy rates are as follows: economic (autopsy is costly and not reimbursable), legal (fear of litigation), attitudinal change ("time-consuming chore"), and exclusion of minimum mandatory autopsy rates as one of the accreditation criteria for U.S. hospitals. There is also the tendency to believe that advances in medical technology provide greater diagnostic accuracy, which make autopsy unnecessary" (Tai et al. 2001: 530-531). O'Connor noted that hospitals that once performed autopsies on 60% or more of their deceased patients have now stopped entirely. Other hospitals that still do autopsies at the request of family members no longer cover the \$2,000-\$3,000 cost (O'Connor 2004). In 1970 the Joint Commission on Accreditation of Healthcare Organizations dropped the requirement that hospitals perform autopsies in at least 20% of all deaths (O'Connor 2004).

393. "Of 1492 patients admitted to the ICU, 315 died, of whom 167 (53.0%) were autopsied" (Combes et al. 2004).
394. In this study looking at consecutive admissions to a medical intensive care unit from January 1, 1994 to December 31, 1995 there were 1,800 admissions. There were 401 deaths, of which 91 were autopsied (22.7%) (Tai et al. 2001).
395. "The Community Quality Index Study differs from previous assessments of quality because it was more comprehensive, examined quality across the nation rather than in one geographic area, and included people with all types of insurance and a wide range of conditions. The research team used random telephone surveys to interview more than 13,000 adults in 12 metropolitan areas regarding their health care experiences. About 6,700 individuals provided written consent for researchers to review their medical records and use the information to evaluate performance on 439 clinical indicators of quality for 30 acute and chronic conditions such as diabetes mellitus, asthma, hypertension (high blood pressure), and heart disease, and for related preventive care" (RAND 2004: 1). Full peer review documentation of this study may be found in (McGlynn et al. 2003) and (Kerr et al. 2004).
396. "Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care. We found little difference among the proportion of recommended preventive care provided (54.9 percent), the proportion of recommended acute care provided (53.5 percent), and the proportion of recommended care provided for chronic conditions (56.1 percent). Among different medical functions, adherence to the processes involved in care ranged from 52.2 percent for screening to 58.5 percent for follow-up care. Quality varied substantially according to the particular medical condition, ranging from 78.7 percent of recommended care (95 percent confidence interval, 73.3 to 84.2) for senile cataract to 10.5 percent of recommended care (95 percent confidence interval, 6.8 to 14.6) for alcohol dependence" (McGlynn et al. 2003: 2635).
397. "An excess of such deaths could be viewed as a signal of possible shortcomings in the health care system that warranted further investigation. For a sentinel disease to be defined as avoidable, there must be identifiable, effective interventions and available health care providers" (Manuel and Mao 2002). "Avoidable mortality" is attributed to (Rutstein et al. 1976); this measure became common in Europe after refinements to Rutstein et al.'s original disease groups (Manuel and Mao 2002).
398. In the *National Post* Douglas Manuel makes the link between outcomes and kind of medical services available more explicit: "Of all these indicators, asthma deaths should be the easiest to avoid," he said. "Asthma rates are going up everywhere. Our health care system has been able to respond, but the U.S. hasn't been able to do that. With good accessibility to family doctors you should be able to avoid asthma deaths because they prevent asthma patients from going to emergency rooms, from going to hospitals and ultimately from dying." A less sanguine professor of public health at the University of Toronto, John Hsieh, responded: "The fact that the avoidable death rate is decreasing is nothing to brag about. It's expected [considering all the advances in scientific knowledge]" Dr. Hsieh said. "It's not the speed a car is traveling at that shows how powerful it is, but its ability to accelerate or in this case I suppose decelerate" (Nelson 2002).



399. "In 1990 asthma mortality was lowest in the United States, but by 2000 it was higher than in Australia and England and approaching the rate of New Zealand" (Hussey et al. 2004: 95). Rates of death from asthma in the United States have increased from 0.8 per 100,000 in 1977 to 2.0 in 1989 and 2.1 in 1994 through 1996 but have decreased to 1.6 in 2000. Age-adjusted rates of death from asthma are "much higher for blacks than whites" (Sly 2004).
400. "Data are drawn from the Commonwealth Fund 2001 International Health Policy Survey and the 2002 International Health Policy Survey of Sicker Adults, both conducted by telephone in Australia, Canada, New Zealand, the United Kingdom, and the United States. The 2001 survey is a nationally representative, cross-sectional sample of non-institutionalized adults in the five countries. The 2002 survey is a nationally representative survey of "sicker adults," defined as those who rate their health status as fair or poor, had a serious illness in the past two years, or had been hospitalized for something other than a normal delivery or had undergone major surgery in the past two years. Approximately 1,400 adults in each of the countries were included in 2001, and approximately 750 sicker adults were included in 2002" (Davis et al. 2004: 3).
401. (Davis et al. 2004: 5-13)
402. See, for example, Census Bureau data that shows 14,776,000 people or 23.5% of those with household incomes less than \$25,000 per year were uninsured compared with 8.2% of those with household incomes of \$75,000 and more. The percentage of people without health insurance that were without a high school diploma was 28% compared with 8.4% for those with a Bachelor's degree or higher (Mills and Bhandari 2003: 2).
403. "After paying for health insurance, you take home less than the minimum wage," says a poster in New York City subway sponsored by Working Today, a nonprofit agency that offers health insurance to independent contractors in New York. "Welcome to middle class poverty" (Strom 2003a).
404. There were 1,625,813 personal bankruptcies for Fiscal Year 2003, which was a 7.8% increase from Fiscal Year 2002 (U.S. Courts 2003: 1). Between one third and one half of all personal bankruptcies are associated with high health care costs (Kaiser Daily Health Policy Report 2003).
405. The authors of this study attribute these changes to declining public sector employment (which provided health insurance to more of its workers) and declining coverage rates among the growing private sector health care workforce (Case, Himmelstein, and Woolhandler 2002: 404-408).
406. "In 2003, the Kaiser/HRET national survey of employers found the average annual premium for employer-sponsored group insurance for a family was \$9,068 with the employer contributing 73 percent of the premium (\$6,656) and the employee contributing 27 percent of the premium or \$2,412 per year. For single individuals, the premiums averaged \$3,383 per year with the employer covering 84 percent of the premium cost (\$2,875 per year) (Rowland 2004: 4). Compared with three years previously, people in employer-sponsored health plans now pay 48% more from their own pockets. "...most employers are

shifting more costs to workers, in hopes of lowering the expense by discouraging heavy use of doctors, hospitals and prescription drugs. Deductibles and co-payments for hospital care, which were uncommon only a few years ago, were required by 4 in 10 plans this year, the study found, and higher co-payments for expensive prescription drugs have been widely adopted" (Freudenheim 2003).

407. A Kaiser Family Foundation study asked 19 insurance companies and HMOs in eight markets to underwrite seven hypothetical applicants. Taken as a group, these seven applicants made 420 applications for coverage. Only 10% (43 offers) received "clean" offers (accepting the applicant for standard coverage at a standard rate). Of the 63% of the applications that were accepted, 53% imposed benefit restrictions, premium surcharges, or both. One patient, a 36 year old HIV positive writer, was denied coverage all 60 times (Pollitz, Sorian, and Thomas 2001). A more recent Kaiser Family Foundation publication points out: "For the average low-income family, a \$9,000 family policy in the individual market would consume a third or more of their income, provide only limited protection, and could exclude coverage for any family member with health problems. Most notably, in many states, private plans individually marketed do not provide routine maternity benefits or, if they do, they are offered as a very costly add-on" (Rowland 2004: 6).
408. Two websites that exemplify this literature are as follows:  
With support from the Robert Wood Johnson Foundation, the Institute of Medicine's Consequences of Uninsurance Committee completed six reports between September 2001 and January 2004. <http://www.iom.edu/> The final report in this series called upon "the federal government to take action to achieve universal health insurance and to establish an explicit schedule to reach this goal by 2010" (Institute of Medicine 2004).  
A range of research reports and policy documents related to the uninsured may be found at the Henry J. Kaiser Family Foundation's website <http://www.kff.org/uninsured/>
409. "One national study found that, over a 17 year follow-up period, adults who lacked health insurance at the outset had a 25 percent greater chance of dying than did those had private health insurance" (Institute of Medicine 2002). "Urban Institute researchers Jack Hadley and John Holahan, drawing from a wide range of studies, conservatively estimate that a reduction in mortality of five to fifteen percent could be achieved if the uninsured were to gain continuous health coverage" (Rowland 2004: 11).
410. The study being cited here by the Institute of Medicine is (Doyle 2001).
411. "The suit filed against Advocate Health Care Network of Oak Brook, Ill., for example, asserts that Jannie Watts, one of the plaintiffs, "received numerous threatening and harassing phone calls' seeking payment of \$48,008.47 for treatment of her uninsured teenage son, a bystander to a shooting who was hit by multiple gunshots in 1998" (Abelson and Glater 2004).
412. Rose Shaffer's heart attack resulted in a \$18,000 bill for her treatment by non-profit Advocate Health Care in Chicago. "The collection people were real nasty," she complained. "They'd call on Sunday, they'd call at 9 o'clock at night. They'd call on the job. My voicemail was full. It was harassment" (Borger 2003). The

Service Employees International Union which has “investigated Advocate and other ‘charitable’ hospitals in the Chicago area” state that Shaffer’s bill would have been \$8,500 if she had been insured (Borger 2003).

413. “In the words of an industry consultant, Michael Zimmerman, ‘self-pay now stands alone as the financial category that will provide the biggest bank for the buck’. ‘It can and should be a cash cow for the hospitals, but it is not,’ Mr. Zimmerman wrote in a newsletter for hospital administrators. He argues that hospitals are not being tough enough when it comes to debt collection from patients” (Borger 2003).
414. Medicare is a federal health insurance program that covers 35 million seniors and 6 million people with disabilities under 65 years of age (Kaiser Family Foundation 2004b: 1).
415. “Medicaid, jointly funded and administered by the states and the federal government, provides health and long-term care services to over 50 million people. The federal government matches state spending for the services Medicaid covers on an open-ended basis, with the federal matching rate, known as the federal medical assistance percentage (FMAP) varying by state from 50 to 77 percent. Each state’s FMAP is based on a formula relationship between a state’s per capita income and the national average per capita income over a three-year period. States with per capita incomes below the national average receive higher matching percentages; states with per capital incomes above the national average receive lower matching percentages” (Kaiser Family Foundation 2004a: 1).
416. “Enacted as part of the Balanced Budget Act of 1997, SCHIP has played an important role in reducing the number of uninsured children. As of June 2003, some 3.9 million children were enrolled in SCHIP nationwide” (Ross and Cox 2003: 1).
417. “The most unusual health care program under Medicare’s purview is the End Stage Renal Disease (ESRD) Program. Dialysis treatment for ESRD is the only health care expense reimbursed by Medicare that people of all ages are entitled to” (Weiss 1997: 131-132).
418. “As a residual program, it is intended to pick up the slack when the market and the family do not meet the need. Medicaid requires individual applicants for benefits to demonstrate not only that they are poor but also that they meet certain other requirements (which vary with the state) (Wildavsky 1992: 318). Laurie Kaye Abraham writes that “Paul Starr calls Congress’s decision to link Medicaid to welfare and Medicare to Social Security the ‘original sin of American health policy.’ ‘Medicare enjoys the political protection created by a span of eligibility that includes the middle class, Medicaid suffers from the political vulnerability created by identification with welfare and the poor’” (Abraham 1993: 176).
419. The culture of welfare offices has been described as “at best brusque or nitpicky, at worse capriciously cruel and punitive” (Abraham 1993: 176). “In the United States, the government agencies that are supposed to be ameliorating, or at least

regulating, the difficulties faced by poor immigrants and their children are, in fact, openly hostile to the plight of their 'clients'" (Bourgois 1995: 242).

420. One example of such a bureaucratic hurdle that affects about two million recipients annually is the administrative practice of "churning" whereby "welfare agencies periodically drop recipients from the rolls incorrectly or for technical violations and then allow them to return after corrections have been made" (Schram 1995: 13).
421. The following discussion about declining access does not even include instances of Medicaid programs that were shibai. Consider, for instance, the Medicaid program, Early and Periodic Screening Diagnosis, and Treatment (EPSDT), in Chicago. "For at least five years, the central office of the Department of Public Aid in Springfield sent cards to all new Medicaid recipients asking them to check a box if they needed help finding preventive care for their children, but it was official departmental policy not to respond to the cards from Chicago mothers, said Diane Hayes, the other Healthy Kids administrator. The Chicago offices were too busy for the extra work, she said. Still, Public Aid's main office went through the motions. The state received about two hundred cards each day, and a secretary dutifully compiled lists of people who had asked for help—only the Chicago lists never left her desk... 'Illinois' general approach to handling programs has been if you don't tell clients about them, they won't use them, and the state won't have to spend money,' the reviewer said" (Abraham 1993: 174).
422. Reasons for the decline in state revenue include job losses in a weak economy that resulted in depressed sales and income tax collection as well as tax cuts of the 1990's (McNichol and Harris 2004: 5).
423. Deficits for the states have totaled approximately \$190 billion from 2001 to 2004. While the federal government provided \$20 billion in fiscal relief to the states in 2003, federal policies have cost states and localities more than \$175 billion from state fiscal year 2002 through fiscal year 2005. The states with the largest net losses from federal policies are California (\$23 billion), New York (\$13 billion), Texas (\$12 billion), Florida (\$11 billion), Illinois (\$6 billion), Michigan (\$6 billion), and Pennsylvania (\$5 billion) (Lav and Brecher 2004: 1). Five areas where federal policies have contributed to the fiscal distress of the states are as follows: federal tax policy, federal preemption of state and local taxing authority, failure of Congress to address Supreme Court rulings that prevent states and localities from collecting taxes owed to them, mandates that require states to spend funds for specific purposes, and federal Medicare and Medicaid policies (Lav and Brecher 2004: 2). Examples of "unfunded mandates" include "homeland security needs" after September 11, 2001 as well as requirements to comply with the Individuals with Disabilities Education Act, The No Child Left Behind Act, and the Help America Vote Act. The National Conference of State Legislatures estimate that unfunded mandates are costing states \$29 billion in 2004 (Lav and Brecher 2004: 9-10). While part of the growth of Medicaid costs may be attributed to the rapid growth of health costs generally, another aspect may be attributed to the gradual shift in the cost of caring for disabled people and low-income elderly to the states from the federal government. As trends in medical care have changed to shorter hospital stays and greater reliance on outpatient therapies, costs have shifted from the federal Medicare program to the federal/state Medicaid program. States are also concerned with the prospect of "new,

unreimbursed costs of \$1.2 billion over the next three years for implementing the new Medicare law” (Lav and Brecher 2004: 10-11).

424. These three states are Colorado, Maryland, and Utah (Ross and Cox 2003: 4).
425. “Encouragingly, emerging research on gender differences in cardiovascular epidemiology has revealed the serious shortcomings of applying “male-based” diagnostic techniques and treatments to female patients. In part, this stems from increased recognition that symptoms of heart attack differ significantly between men and women. Of particular concern is recent evidence that life-threatening delays in diagnosis (via EKG) of women may occur because of lack of awareness of the unique nature of female symptomatology” (Ostlin, George, and Sen 2003: 143). Death after myocardial infarction is higher for women than men (Bergelson and Tommaso 1995: 1511-1512).
426. In this study “white, male, young, nondiabetic, high-income patients treated in smaller units were more likely to receive a cadaver transplant under Medicare than are other kidney patients” (Held et al. 1988). A prospective cohort study of 7,125 patients done between January 1993 and December 1996 found that blacks, women, and poor people were less likely than whites, men, and wealthy people to complete the steps of the transplantation process (Alexander and Sehgal 1998).
427. Yentl was named after the heroine of Isaac Bashevis Singer's short story. Yentl had to disguise herself as a man to attend school and study the Talmud at an all-male Jewish school in 19th century Poland.  
<http://www.whonamedit.com/synd.cfm/2850.html>
428. Despite reports by women of symptoms consistent with greater functional disability from angina, fewer women had undergone cardiac catheterization (15.4 percent of women vs. 27.3 percent of men, P less than 0.001) or coronary bypass surgery (5.9 percent of women vs. 12.7 percent of men, P less than 0.001). When these variables were adjusted for important covariates, men were still twice as likely to undergo an invasive cardiac procedure as women, but bypass surgery was performed with equal frequency among the men and women who did undergo cardiac catheterization” (Steingart et al. 1991). Much depends on symptom interpretation. “Data suggest that women, once they reach the cardiac catheterization laboratory, are as likely as men to receive an interventional coronary procedure. However, there appears to be a gender bias earlier in the decision-making process that concerns subjective interpretation of symptoms and conditions, not admitting diagnosis or results of objective testing that prevents women from having coronary arteriography (Bergelson and Tommaso 1995: 1512).
429. See for example, *Key Facts: Race, Ethnicity & Medical Care* (Lillie-Blanton, Rushing, and Ruiz 2003), which is done in chartbook format, available at:  
<http://www.kff.org/minorityhealth/index.cfm>
430. The “Why the Difference?” campaign is sponsored by the Kaiser Family Foundation and the Robert Wood Johnson Foundation to “raise physician awareness about disparities in medical care.” An example of their publications is a meta-analysis of peer-review literature to evaluate the evidence of racial/ethnic differences in cardiac care (Kaiser Family Foundation 2002).

431. The examples in this section may be compared with the "Patterns of Global Terrorism" report released in April 2004 that "claimed to document a sharp fall in terrorism." These results were used by the Bush administration as evidence of winning the War on Terrorism: "'You will find in these pages clear evidence that we are prevailing in the fight,' Deputy Secretary of State Richard Armitage declared" (Krugman 2004). Revised statistics by the State Department show that the number of significant international terrorism episodes and the number of injuries resulting from such episodes increased rather than decreased as the original report claimed (Weisman 2004). Responsibility for these errors was attributed by experts from the State Department and the Terrorist Threat Integration Center as "a combination of technical and human errors, including an obsolete database and computer program" (Weisman 2004). Although technical errors share the blame with amorphous human error in this example, what is similar is the insistence by J. Cofer Black of the State Department that errors in this report "were honest mistakes, and certainly not deliberate deceptions as some have speculated" (Weisman 2004).
432. Selected examples include: the administration deleting or demanding changes to climate change reports prepared by the Environmental Protection Agency, censoring information on air quality that would have implications for regulation of power plants, evaluating abstinence programs by attitudes and attendance to obscure lack of efficacy, posting of refuted claims that there is a connection between abortion and breast cancer on the National Cancer Institute website despite objections from CDC staff, prohibition of publication of USDA research demonstrating potential hazards of air-borne bacteria from farm waste, and systematic attempts to weaken the Endangered Species Act (Union of Concerned Scientists 2004).
433. Union of Concerned Scientists (2004: 2) findings:
- There is a well established pattern of suppression and distortion of scientific findings by high-ranking Bush administration political appointees across numerous federal agencies. These actions have consequences for human health, public safety, and community well-being.
  - There is strong documentation of a wide-ranging effort to manipulate the government's scientific advisory system to prevent the appearance of advice that might run counter to the administration's political agenda.
  - There is evidence that the administration often imposes restrictions on what government scientists can say or write about "sensitive" topics.
434. Major General Antonio Taguba's investigation showed "numerous instances of 'sadistic, blatant, and wanton criminal abuses' at Abu Ghraib prison in Iraq (Hersh 2004). "Army Intelligence officers, CIA agents, and private contractors 'actively requested that MP guards set physical and mental conditions for favorable interrogation of witnesses'" (Hersh 2004). These "physical and mental conditions" were undoubtedly informed by notions of Taliban and Al Qaeda prisoners termed "unlawful combatants" that Defense Secretary Rumsfeld said of, as early as January 2002, that "technically" they "do not have any rights under the Geneva Convention" (Sontag 2004). After helping to create a culture that justifies torture, "Rumsfeld condemned abuses of Iraqi prisoners by U.S. soldiers as 'totally unacceptable and un-American'" (Associated Press 2004e). President

Bush said, "The actions of these few people do not reflect the hearts of the American people" (Stout and Neilan 2004). A Justice Department report offering legal justifications and defenses for disregarding torture laws was instigated by Guantanamo interrogators frustrated with "recalcitrant" prisoners who argued "we need to have a less-cramped view of what torture is and is not" (Bravin 2004). Bush tried to spin this report for his own purposes. "The instructions went out to our people to adhere to law. That ought to comfort you," President Bush said brusquely when questioned last week about a Justice Department legal opinion authorizing harsh interrogation techniques....Contrary to Bush's account, the Justice Department memo wasn't an affirmation of laws that ban torture. Instead, it was a legal interpretation explaining how CIA interrogators could avoid liability under those laws, even if they used methods that might commonly be regarded as torture" (Ignatius 2004). As this *Washington Post* analysis argues: "When the Abu Ghraib scandal broke, top Bush administration officials tried to dismiss it as the work of 'a few bad apples.' But it is increasingly clear that the problem is with the barrel, not just the apples. Abu Ghraib was a particularly graphic and appalling instance of an archipelago of cruel interrogation techniques that were explicitly authorized by the administration" (Ignatius 2004). The difficulty of recognizing the problem of the barrel is elegantly illustrated by an essay by Susan Sontag in her description of an administration more concerned with a public relations disaster rather than the real disaster. "The administration's initial response was to say that the president was shocked and disgusted by the photographs—as if the fault or horror lay in the images, not in what they depict. There was also the avoidance of the word 'torture.' The prisoners had possibly been the objects of 'abuse,' eventually of 'humiliation'—that was the most to be admitted. 'My impression is that what has been charged thus far is abuse, which I believe technically is different from torture,' Secretary of Defense Donald Rumsfeld said at a press conference. 'And therefore I'm not going to address the 'torture' word'" (Sontag 2004).

435. Allan Bromley, physicist at Yale and science advisor to the first President Bush, said, "You know perfectly well that it is very clearly a politically motivated statement." Russell Train, who represented the Union for Concerned Scientists and served as an administrator of the Environmental Protection Agency under Presidents Nixon and Ford said, "I don't see it as a partisan issue at all. If it becomes that way I think it's because the White House chooses to make it a partisan issue" (Glanz 2004).
436. Evans (1999: 27) attributes the "steersman metaphor" to R. R. Nelson, 1977, *The Moon and the Ghetto*, New York: Norton.
437. "The same arguments come forward year by year, decade by decade, in every country, and in virtually the same forms of words, regardless of how many times they are refuted....The arguments for private markets and private financing presented to (and rejected by) the Royal Commission on Health Services were brought forward in the early 1970s to support high deductible, high coinsurance private coverage in the United States, and have resurfaced as the 'medical savings accounts' of the 1990s. The labels change, but the 'new' ideas—haven't" (Evans 1999: 27-28).
438. Kickbush notes that by the positioning of health as the responsibility of the nation state "how health was distributed in society became a political issue: the

challenge was 'to put health on the political agenda'" (Kickbush 2000: 981). Halfdan Mahler, Director General of the WHO at that time, explained in 1982 that "Health for All" means "...that people will use much better approaches than they do now for preventing disease and alleviating unavoidable illness and disability, and that there will be better ways of growing up, growing old, and dying gracefully. And it means that health begins at home and at the work place, because it there, where people live and work, that health is made or broken. And it means that essential health care will be accessible to *all* individuals in an acceptable and affordable way, and with their full participation" (Morley, Rohde, and Williams 1983: 319).

439. Other examples of global public goods are justice, peace, the environment, and knowledge.
440. Kaul and Faust, Chen et al., and Kickbush all support the concept of health as a global public good which should be used as a foundation for global health policy. Kickbush further prescribes "WHO's task must be to establish health firmly as a global public good and ensure that it is supplied with fairness globally" (Kickbush 2000: 985).
441. While one might personally agree with Dr. Lee's destination, one might still have reservations about his description of the means of achieving it. The assumption that increased technical skills, methods to measure effectiveness, and values of stewardship and justice will make a difference without addressing political, economic, and social causes of ill health is perhaps faulty. The framing of health as a technical problem to be solved with more skills, resources, and determination did not permit HFA2000 and arguably will not permit HFA5000. An additional concern is that framing health for all as enlightened self-interest at a time of backlashes against globalization, multiple sites for War on Terrorism, and increasingly mobile microbes generates resources but it also mobilizes surveillance of people coded as dangerous.
442. Deborah Stone describes ambiguity as the "glue" of politics as agreement becomes possible as people read different meanings into the words of laws and policies. The ambiguity of symbols may "quell resistance to policies by reassurance at the same time as actual policies deprive. In all these ways, politics obey the laws of poetry rather than the laws of matter: a program or policy or speech, unlike a physical object, can be two things at once. But if symbols are the invisible hand of politics, it not because there is any overall force coordinating individual decisions, but because they enable us as individuals to 'read ourselves into' social programs and collective action" (Stone 1997: 161-162).
443. All biographical information on Michael Savage is from the his website which was accessed on May 7, 2004:  
<http://www.homestead.com/prosites-prs/Savage.html>
444. The Paul Revere Society (PRS) is a non-profit organization (501 c 3). "The United States is threatened and the PRS stands for the reassertion of our borders, our language, and our traditional culture." Their eight point program is as follows:  
The Paul Revere Society 8-Point Program

1. Support Traditional Marriage



2. Close the Borders now.
3. Deport all illegal immigrants now.
4. Eliminate bilingual education in all states.
5. Require health tests for all recent foreign born immigrants.
6. Make tax cuts permanent.
7. End Affirmative Action
8. Tort Reform - Stop Class Action Lawyers.

Website accessed June 27, 2004

<http://www.homestead.com/prosites-prs/index.html>

445. Savage's racism is coded within his stances against affirmative action, bilingual education, and immigration. His views on inmates must be understood in the context of racial coding of the criminal justice system in the United States. One out of every 75 men in the United States is in prison. In 2003, 68 percent of all jail and prison inmates were members of ethnic or racial minorities. An estimated 1.6 percent of white men, 3.7 per cent of Hispanic men, and 12 percent of all black men in the 20's age-group were in jail or prison in 2003 (Associated Press 2004c).
446. The economic blockade of Cuba by the United States was imposed in 1961 but was mitigated by capital and resources from the Soviet Union. The fall of the Soviet bloc in 1989 disrupted 85% of Cuba's foreign trade and Cuba's ability to import petroleum, manufactured goods, and food. The Torricelli Bill of 1992 explicitly extended the embargo to food and medicines. Medical supplies that are only produced in the United States that could no longer be purchased included "the only effective treatment for pediatric leukemia, x-ray film for breast cancer detection, U.S.-made replacement parts for European-made respirators, and Spanish-language medical books" (Chomsky 2000: 351). The Ministry of Foreign Trade in Cuba estimated the excess costs to the health system of the U.S. blockade to be \$45 million per year (Chomsky 2000: 352). Aviva Chomsky persuasively argues that efforts by the United States to undermine Cuba by economic blockade and sabotage, chemical and biological warfare, invasion and subversion "for 40 years pursued its goal of destroying the 'threat of a good example' that Cuba's success in health and social justice provide" (2000: 356).
447. Cuba has one of the highest rates of physicians per population in the world at one doctor per 200 inhabitants (Chomsky 2000: 354). David Werner criticized the Cuban health care system for being "top-heavy" in relying too much on provision of health care by physicians instead of increasing responsibility to community health workers (Werner 1983).
448. "An improvement in child mortality in Harlem between 1960 and 1980 was accompanied by rising mortality rates for persons between the ages of 25 and 65. There was therefore no improvement in overall age-adjusted mortality. Death rates for those between the ages of 5 and 65 were worse in Harlem than in Bangladesh" (McCord and Freeman 1994: 39).
449. This metaphor of "cooling the mark out" is from (Goffman 1952).
450. "The mark is the sucker—the person who is taken in.....The persons who operate the racket and "take" the mark are occasionally called operators" (Goffman 1952: 451). The typical play is as follows: "The potential sucker is first

spotted, and one member of the working team (called the outside man, steerer, or roper) arranges to make social contact with him. The confidence of the mark is won, and he is given an opportunity to invest his money in a gambling venture which he understands to have been fixed in his favor. The venture, of course, is fixed, but not in his favor. The mark is permitted to win some money and then persuaded to invest more. There is an "accident" or "mistake," and the mark loses his total investment. The operators then depart in a ceremony that is called the blowoff or sting. They leave the mark but take his money. The mark is expected to go on his way, a little wiser and a lot poorer" (Goffman 1952: 451).

451. According to the Tim Peters and Company, Inc. website, the creator and publisher of the Dr. Wellbook Collection is Tim Peters. His company has "earned an international reputation as the innovative company that 'humanizes medicine'." It is fascinating to note that humanizing medicine is done through the extensive use of animal characters. Other titles in the Dr. Wellbook Collection include: *I'm Still Me, Coping with Leukemia* (featuring Herbie, the Chick); *Ellie the Elephant has an Earache*; *Bear Spot Learns a Lot, Growing up with Diabetes*; *Hooray for Harold, Dealing with Hearing Loss* (staring Harold the Mouse); *Toby Turtle Takes a Tumble*; and *Toby and Margo, Teamwork Makes It Happen* (Toby is a Turtle and Margo is a mouse). <http://www.timpetersandcompany.com/>
452. In the five books reviewed (Peters 1994, 1996a, 1996b, 1996c, 2003), none of the protagonists needed to be prepared for imminent death as in Goffman's example of physicians as coolers but three of the five did need to be consoled for being different from their age-mates.
453. Maxine, the "quietest bunny," hides when the rest of the family goes to "discuss the role of vaccines" with Dr. Gruff, a goat. While hiding out in the farm yard, Maxine narrowly avoids discovery by the farmer, being eaten by a cat, and is scolded into compliance by a cow and a rooster (Peters 1994).
454. Not incidentally, many of these vaccines mentioned by Dr. Gruff in excruciating detail are manufactured by Merck, whose logo appears on the back of *Maxine's Vaccine* along with the acknowledgment "presented as an educational service by Merck Vaccine Division." Another Dr. Wellbook text that is linked to a pharmaceutical company is *Dotty the Dalmatian Has Epilepsy*. The front cover of this booklet is printed "Compliments of Novartis Pharmaceuticals Corporation, maker of Trileptal®" although it was purchased from Tim Peters and Company, Inc. for \$8.95. Complete prescribing information for the antiepileptic drug Trileptal (oxcarbazepine) in the form of an insert glued to the back cover of this text suggests that the target audience of this publication is physicians as well as epileptic children and their families. As with the example of the Arthritis Self-Management Program in Chapter 5 where arthritis patients have the opportunity to underwrite Pfizer's cost to market Celebrex to themselves, purchasing *Dotty the Dalmatian Has Epilepsy* gives the families of epileptic children the opportunity to underwrite part of the cost of marketing Trileptal to themselves.
455. Dr. Gruff says, "These vaccines will help protect you against serious diseases. Getting vaccinated on schedule is the best way to help keep a little bunny healthy" (Peters 1994: 13).

456. "This relationship is not 'approximately true,' reflecting the fact that health is a labour-intensive industry. It is *exactly* true, part of the accounting identity above. Income is received in various forms—wages, salaries, income from independent practice or unincorporated business, rent, interest, and dividends, etc. But in total it must add up to total expenditure, unless an arithmetic error has been made" (Evans 1999: 35).
457. The extent to which physicians are key decision makers in the health care system is confirmed by Bradford Gray who writes "approximately 75 percent of the ongoing expenditures in health care are attributable to decisions made by physicians" (1991: 166). This quantification of physicians' decisions affecting "more than three fourths of all medical services," while "physicians are directly responsible for only approximately 20% of healthcare utilization is also the point of departure for Sheldon Retchin on approaches to the modification of physician practice patterns (1997: 202).
458. Who says medical journals have to be dull? "If the medical school in Grenada had remained closed for 10 years, the Reagan administration would have saved the U.S. taxpayers more than \$7.9 billion (50 graduates per year, with average time in practice of 35 years at \$450,000 per year). The Department of Defense calculates the cost of the Grenada invasion at \$134.4 million (not including military pay). One can thereby calculate a favorable benefit-cost ratio of 59:1" (Maloney and Reemtsma 1985: 1713). Their short "Occasional Notes" concludes with a warning about the surfeit of physicians in California. "The Auditor General has reported that the state has an excess of 10,000 physicians and that even if the University of California closed its five medical schools tomorrow, the excess would continue to worsen because of the influx from other states and nations. If we don't move quickly, President Reagan may send in the 82<sup>nd</sup> Airborne" (Maloney and Reemtsma 1985: 1713-1714).
459. The Council on Graduate Medical Education (COGME) was authorized in 1986 as an advisory council to Congress and the Secretary of the Department of Health and Human Services on issues related to the physician workforce and graduate medical education (Council on Graduate Medical Education 2002: xi). The summary report of their findings from 1986 to 2002 confirms the framing of much of the discussion in this dissertation. The "major responsibility to monitor the Nation's supply of physicians and recommend policy changes" is put in the context of the U.S. health care system "in crisis" (Council on Graduate Medical Education 2002: 3). "COGME recognized that health care reform to ensure access to basic care for all Americans is not possible without physician workforce reform" (2002: 3). The rationale for this uses the now-familiar triad of access, efficiency, and quality to tie together the dynamics of health care reform and issues related to the physician workforce. "The state of the Nation's health care workforce directly affects both the health of the American public and the economics of health care. To the extent that the health workforce proves inadequate in numbers or geographical distribution to meet the needs of the public and the systems of health care in the country, then access to quality health care may be impeded, and overall health status may be affected. To the extent that the workforce becomes unbalanced in relation to the public's need for specific types and numbers of health care practitioners, then the system becomes inefficient and suboptimal in the quality of its processes and outcomes" (Council on Graduate Medical Education 2002: xi).

460. This was a retrospective cohort study based on claims from the Medicare program. The cohorts considered received care from 77 hospitals that appeared on the 2001 *US News and World Report* "best hospitals" list for pulmonary, heart, cancer, and geriatric services. The study population of people who received care during the last six months of their lives included 115,089 people, 85% of whom were chronically ill (Wennberg et al. 2004).
461. This cohort study looked at Medicare beneficiaries hospitalized between 1993 and 1995 for hip fracture (n = 614,503), colorectal cancer (n = 195,429), acute myocardial infarction (n = 159,393) and a representative sample (n = 18,190) drawn from the Medicare Current Beneficiary Survey (Fisher et al. 2003).
462. Eisenberg attributes "Roemer's Law" to (Roemer 1961) and suggests it might be a parallel argument to the "technological imperative" whereby "the mere availability of biomedical technology induces its use" (Eisenberg 1986: 14). When reviewing the literature, Eisenberg noted studies that showed physician inducement for services occurs where physician discretion is greater (e.g. ambulatory care and diagnostics), physicians provide intensities of care depending on the "the need to recoup lost income when their reimbursement changes," and doctors in areas with a high density of physicians as well as high income physicians tended to be stronger advocates of aggressive treatment (1986: 16-17).
463. Going back prior to Friedson, the field of medical sociology and the study of medicine as a profession have been traced back to Talcott Parsons (1951).
464. An illustration of this may be found in a letter written by the husband of a woman who died on May 29, 2004 to her unnamed oncologist. Although the physician was medically competent in the care of this woman with lung cancer, the husband said to the doctor that his abandonment of the patient at the end of her life constituted "a grave breach of the moral contract you entered into with her." The husband wrote: "...your coldness during her final weeks made it more difficult for us because she felt that she had lost the medical anchor you had provided and no longer had a doctor she could trust to explain what was happening to her as her body withered and her vulnerability grew. Much precious time was wasted trying to turn her mind from your dismissal of her that she experienced as a professional and personal betrayal. Which I believe it was. Would it have cost you so much, doctor, to have picked up the telephone to speak with her after almost seven years of treatment? Would it have been so intolerable to you to have looked into her eyes - at the hospice perhaps - and told her that you wished her well and wanted a chance to say goodbye? Were you truly unable to offer even a shred of comfort, a word of condolence to her family? Had she really become no more than another statistic, a failure you preferred to brush aside?" (Brody 2004)
465. Books such as *The Overworked American* (Schor 1991) and *White-Collar Sweatshop* (Fraser 2001) document the ever increasing demands on all working Americans, including those in professional occupational groups, which make the hours worked by physicians perhaps less remarkable than in previous generations. An awareness of people who have died in the line of duty as a result of the events of September 11, 2001 and the occupation of Iraq and Afghanistan by the United

States might also contribute to a notion of medicine as demanding work with commitments that are relative. Prominent work-related sacrifice include the deaths of 343 New York City firefighters, 37 Port Authority police officers, and 23 New York City police officers due to the collapse of the World Trade Center (National Commission on Terrorist Attacks Upon the United States 2004: 311) and the 1,003 members of the United States military who have died since the start of the military operations in Iraq from March, 2003 to September 7, 2004 (Associated Press 2004a).

466. An example might be found in Dr. David Pomrinse's comment during the 1975 strike by the Committee of Interns and Residents that if there "were really anything wrong with the way we train doctors we'd have realized it during the hundred years or more that we've been doing it this way" (Wolff 1990: 59).
467. In published reports that Kassebaum and Cutler reviewed on student abuse, "from nearly half to virtually all students—depending on the study—report one or more incidents of abuse during medical school" (1998: 1149). In their article they "portray the recent climate of student abuse in U.S. medical schools, drawn from surveys of graduating medical students in 1992, 1994, and 1996. We address the pathogenesis of this sinister side of teaching and supervision, and recommend a program of actions aimed to achieve a culture for learning that is less inimical to the professional behaviors that students are expected to acquire" (Kassebaum and Cutler 1998: 1150). "Of the 13,168 GQ respondents, 5,049 (38.3%) reported that they had been publicly belittled or humiliated at least once during medical school" (Kassebaum and Cutler 1998: 1151).
468. House officer training is often even worse as this general medicine resident at a university-affiliated, inner city hospital remembered: "Constantly learning by mistakes rather than being guided is no way to be trained as a doctor, but that's how I was trained here. It was inhuman, demoralizing. There was no emotional support. Patients were dying all the time. I was getting so distanced from them, and I'd do a head count in the morning to see who was still alive. There was more work than anyone could possibly have done. I was overwhelmed by it. I couldn't do it even though I was spending 120 hours a week at the hospital. Sometimes at four in the morning I was so exhausted, I just didn't give a shit anymore and I'd go to bed. I just didn't care. It was a matter of self-preservation ... (related examples of how he feels he treated patients badly)... What I saw was my failure as a physician and as a human being. I'm a resilient person and it takes a lot to knock me down, but I couldn't take this anymore. I had reached the point where this experience had made me into someone I did not like. After my year there, I was so burned out and soured, I quit medicine for six months" (Pekkanen 1988: 9-10).
469. Medical school student culture may be considered to be a "complex of mutual expectations" (Becker et al. 1961: 435). "...culture is commonly defined as a body of ideas and practices considered to support each other and expected of each other by members of some group of people. Such a group forms a *community of fate*, for however individualistic their motives, they share goals, a body of crucial experiences, and exposure to the same perils" (Becker et al. 1961: 435).
470. Medical students often make the case that things are the worst for them at the lowest end of the academic feeding chain as the following example suggests:

"The other harsh aspect of the clinical years is that the medical student is at the very bottom of a fairly rigid hierarchy. There are often interns and residents who need someone to dump on; they are under a great deal of pressure, they are sometimes treated roughly by senior doctors, they are deprived of sleep—and when they need to kick the proverbial cat, there is the medical student. The experience of always being treated like someone who doesn't matter, of being made to wait constantly, of casually being told to go do this and that, of having your best efforts mocked or your ignorance held up for all to see—this can make you desperately resentful. 'For this I'm paying a thousand dollars a month,' I used to hiss through clenched teeth" (Klass 1987: 57).

471. "To say that they are young, white, male, Protestant, small-town native Kansans who are married describes a very sizeable majority of the entire student body" (Becker et al. 1961: 59). The overwhelming majority of students are men, but each class contains a number of women, ordinarily around five. Similarly, the overwhelming majority of students are native-born and white. Each class will contain a few students from such faraway places as Central America or Africa, as well as a number of American Negroes, possibly four or five. The small numbers of women and Negroes do not reflect any intent to discriminate. The school gets very applicants of either category" (Becker et al. 1961: 60).
472. This fuller quotation is from January 1956: "I was having a Coke with Craig. He said, 'I'll tell you one thing, you'll never catch me doing any charity work.'" I said, "Someone's got to do it, don't they?" He said, "I have some pretty bizarre thoughts on that subject. The way I feel is if they can't pay for it they don't deserve to get it.... Not all of them, but you take the kind of guy who thinks it's more important to make the payment on his television than to pay his doctor bill. He figures that if he doesn't make the t.v. payment they'll come and take the set away. But the doctor can't take back the shot of penicillin he got. So he lets the doctor wait. Now a guy like that I would just have no sympathy for at all" (Becker et al. 1961: 319).
473. **Pimping** is "Put In My Place, rapid fire questioning of a trainee by a superior" (Coombs et al. 1993: 990). For example: "During third year clinical clerkships, preceptors would grill my classmates and me on our understanding of clinical issues in front of other medical students, residents, and patients. This system of pimping was intended to probe our knowledge, to demonstrate the important points, and to check that we assimilated new information appropriately. It presented us with the opportunity to flaunt what we knew or to humiliate ourselves through our ignorance" (Rothman 1999: 107). "**Suck points**" are "brownie points gained by deliberate ingratiation with one's superiors" (Konner 1987: 388). An attending physician may be known as a "shark" who "attacks and 'shreds' medical trainees without provocation" which may take place during "offending rounds" decoded as "stressful attending rounds" (Coombs et al. 1993: 990). This may result in **BOHICA** or "Bend Over Here It Comes Again" (Coombs et al. 1993: 990).
474. A survey of 744 subjects ranging from pre-medical students to physicians with 50 years of experience, all affiliated with a large university teaching hospital in the United States, provides some insight into patterns and functions of medical slang. This insider phenomenon is uncommon in the first two years of medical school but becomes increasingly common as medical students enter the clinical

setting in their third year. Usage of medical slang increases through the later years of medical school until it peaks during the “most hellish” year of internship when hours average more than 90 per week, and sometimes range as high as 120-140 hours per week (Coombs et al. 1993: 996) . Slang usage “levels off” during the still demanding and stressful five years of residency, fellowship (years 1-4), and first five years of post-training practice, and then gradually declines. Doctors practicing for 20 or more years “are only slightly more familiar with slang terms than medical students who have not yet begun clinical training” (Coombs et al. 1993: 992). This data did not show significant differences in slang usage between male and female subjects (Coombs et al. 1993: 992).

475. As a tiny illustration of both globalization and localization, one might consider similarities and differences in medical slang in biomedical cultures separated by the Atlantic Ocean. Some terms are virtually identical in both the American and British lexicons such as: **C.T.D.** (circling the drain, said of a patient who is dying) (Konner 1987: 382; Fox et al. 2003: 183) ; **F.L.K.** (funny looking kid, a child whose physical characteristics suggest the possibility of genetic disease or who might be “just like dad”) (Konner 1987: 383; Fox et al. 2003: 184) ; and **Triple P or PPP** (piss poor protoplasm, refers to the overall problem in a patient who keeps getting different serious illnesses without ever getting better) (Konner 1987: 389; Fox et al. 2003: 186). Some variations in terminology might be seen to demonstrate either emphasis on different etiological possibilities and/or idiosyncratic adjectival preferences more than substantive content: **B.F.I.** (big fuckin’ infarct, includes both massive myocardial infarction (heart attack) and stroke) (Konner 1987: 380) while **M.F.I.** (mother fucking infarction refers more specifically to “a very large myocardial infarction”) (Fox et al. 2003: 186). Either way, there is grave danger that the patient is **T.F. BUNDY** (totally fucked but unfortunately not dead yet (Fox et al. 2003: 188). Regional variations that are fascinating for the hints that they reveal about the sensibilities of those doing the describing perhaps more than who or what is being described include: **GROLIES** (*Guardian* reader of limited intelligence in ethnic skirt) (Fox et al. 2003: 185), **NFN** (normal for Norfolk, “another possible etiology of an FLK”) (Fox et al. 2003: 186), and **TEETH** (tried everything else try homeopathy) (Fox et al. 2003: 188).
476. **Scut**—routine daily ward work, sometimes dirty but often just paperwork, of which there is a vast amount; done by the lowest person on the totem pole who can legally do it, and who can be trusted not to do is so badly that he or she creates more work instead of doing some of it; sometimes ironically interpreted as ‘some clinically useful training’” (Konner 1987: 388). A person on the medical team who gets to enjoy this clinically useful training may be called a “scut puppy,” “scut dog,” or “scut monkey” (Coombs et al. 1993: 990).
477. “**Gomer**: acronym for Get Out of My Emergency Room; refers to an old, decrepit, hopeless patient whose care is guaranteed to be a thankless task; usually admitted from a nursing home. **Gomere**: Female *gomer*; pronounced ‘go-mare,’ as if it were a feminine ending in French; which, through an ironic sort of gentility, gives the old demented woman a sort of touching respect even while allowing the house officer yet another kind of mockery” (Konner 1987: 383).
478. “**Turf**: One of the most common and important verbs used by house officers; to transfer a patient, as quickly and as permanently as possible, to another service,

to the street, or (when all else fails) to the morgue; viewed in the minds of some house officers as a flashing neon sign: TURF TURF TURF" (Konner 1987: 389). This is often combined in common usage with the verb "to buff" "meaning to make a patient better, or at least to look better, by the signs and by the numbers; an improvement, but by no means necessarily a cure; 'I've got that pneumonia the surgeons *turfed* us so buffed they'll never recognize him when I turf him back'" (Konner 1987: 381).

479. Tensions between medicine and surgery services are often paradigmatic. "...most of the medical residents on our tapes feel that the surgeons foist their work and responsibilities upon them, without displaying any other collegial behavior" (Stern and Caldicott 1999: 245).
480. Within (Coombs et al. 1993: 991)'s extensive catalogue of slang referring to undesirable patients "lacking wit and social status," the following selected terms stand out from the list:
- |                             |  |
|-----------------------------|--|
| Dirtbag; Scumbag; Slime Dog | A dirty, smelly patient off the street   |
| CLL                         | Chronic low life   |
| FUR                         | Found under Rock; patient is a low life  |
| SHPOS                       | Sub-Human Piece of Shit  |
| Yellow Bellied Sap Sucker   | Alcoholic with liver disease   |
| Nonpayoma                   | Patient without funds  |
| Strawberry                  | A female patient who prostitutes for drugs   |
| Squid                       | Sick "queen" with immune deficiency  |
| DIAL Syndrome               | Dumb In Any Language, patient from whom it is difficult to extract information           |
| LMC                         | Low Marble Count, stupid   |
| Lights On, Nobody Home      | An "empty headed" patient who doesn't seem to understand what is being said or explained |
481. The full quotation is as follows: "...no normal person can assume such responsibility, do such bizarre things to people, inflict such pain, make such heavy decisions. So the person must be temporarily rendered abnormal. When your beeper wakes you up after two hours' sleep (having not let you rest for thirty hours before that) and you roll out of your cot and rush to the bedside, you will be faced with decisions no person should have to make—decisions on which life will depend but which in their nature cannot be carefully considered. The fatigue and stress make you care a little less; they enable you to make the decisions. You do it in a daze. And after doing this hundreds and then thousands of times, they are not longer deliberate or even confused, but reflexive. You have learned to bypass existential moralizing and to grapple with a grotesque pragmatic reality that cannot be ignored. Eventually, you will do this even when you are well rested and not under any stress. And when that happens you have become a doctor" (Konner 1987: 373).
482. "Rule of Learning: See one, do one, teach one" (Konner 1987: 388). A modification of this rule is "Galen Rule of Learning: See one, screw one, do one" (Konner 1987: 383).



483. Another illustration of an adverse outcome for a patient that was widely reported occurred in January 2002 when a 57-year-old man died three days after donating part of his liver to his brother at Mount Sinai Hospital. The New York State Commissioner of Health said that poorly supervised residents provided "woefully inadequate postsurgical care" as the hospital was fined \$48,000 and banned from doing live-donor organ transplants for six months (Grady 2002).
484. "MECCA" is a term used for tertiary care hospitals (Coombs et al. 1993: 989).
485. "**Horror show**: an extreme mess in which either 1) one mistake after another leads to a relentless, intractable, and usually very ugly deterioration; or less commonly 2) the patient's condition itself leads to the same sort of result" (Konner 1987: 384). This may be contrasted with "**Train wreck**: total medical disaster, but (unlike 'horror show') not from physician error; patient with multiple trauma, or simply with several superimposed illnesses; not a hopeful designation (Konner 1987: 389). Slang referring to death includes "went into Electrolyte Heaven" which is "iatrogenic death from overzealous attempts to correct electrolyte imbalance" (Coombs et al. 1993: 994).
486. The following incident occurred on an obstetrical rotation: "...they wish to call attention to their belief that they are really worthy of greater amounts of responsibility and to what they believe to be the absurdities of the routine denials of that responsibility....In extreme and unusual cases students may deliberately misuse small responsibilities for this reason: A student I was spending some time with was required to do a blood count on a patient he regarded as not being sick at all. He drew a syringe full of blood and carried it out to the nurses' station. In front of the nurse, he held the syringe up to the light, looked at it, and handed it to her, saying "Here, you can have this now. I've done my blood count and differential." The nurse looked at him and laughed nervously. He said, 'Oh well, with somebody like her, what the hell difference does it make? She isn't likely to have any hematological trouble. We'll just fill it in with normal values. That will be all right.'" While the nurse giggled, the student took the chart, opened it up to the page where lab results go and said, "Let's see, her blood looked pretty good. I'll put down twelve grams of hemoglobin, that's about 77 per cent of normal." He wrote down these figures and filled in imaginary figures for the other values to be reported. I said, 'Tell me, do people turn in lab results like this very often?' He said, "Sure they do. What the hell, she hasn't got anything that needs a blood count. It's just a lot of damn fool scut work. I'll show that goddam Jones." (Jones, the patient's doctor, was a member of the staff this student particularly disliked, feeling that he, more than other staffmen, tried to 'Keep the students in their place.')
- (Becker et al. 1961: 264-265).
487. "One medical student put his stethoscope on a patient's chest and reported he heard a murmur. The problem was, he'd forgotten to put the stethoscope's earpieces in his ears. We all fake things like this in medical school and in practice. Right now in medicine, it's going on all the time, all over the country. Doctors are faking their physical diagnoses, putting things on a patient's chart that have no connection to what they've actually done or observed. Fudging at the margins is something you learn in medical training and you usually get away with it. Unless of course you do something as obvious as forgetting to put in your

earpieces. Only rarely does it happen that what you didn't do turns out to be the crux of the diagnosis" (Pekkanen 1988: 30).

488. Illustrations of this come out in the medical literature in the 1990's as a flurry of articles document patterns of misrepresentation by applicants to residency programs across specialties. Among 64 potential orthopedic residents who listed publications, 11 (17%) misrepresented their publications by non-authorship of existing articles or authorship of non-existent articles (Dale, Schmitt, and Crosby 1999). Of the 147 pediatric residency applicants who claimed authorship of publications, 29 (19.7%) contained at least one unverifiable publication (Bilge, Shugerman, and Robertson 1998). Among emergency medicine residency applicants who claimed publications, 23 (20.4%) misrepresented citations with the number of misrepresentations increasing with the number of citations cited (Gurudevian and Mower 1996).
489. Gaming the credentialing system may be even worse among fellowship applicants. Among those who listed published articles, 16 applicants (30.2%) to a gastroenterology fellowship misrepresented their publication records by listing articles in nonexistent journals, listing nonexistent articles within actual journals, and listing articles "in press" without citing the name of the accepting journal (Sekas and Hutson 1995). Among 14 applicants who claimed publications for a pediatrics fellowship, at least one publication was unverifiable for each applicant. Of the total 77 publications claimed by the 14 applicants, 31 (40%) could not be confirmed (Bilge, Shugerman, and Robertson 1998). Not mutually exclusive hypotheses to explain why a fellowship applicant would misrepresent information suggested by the authors include: 1) competitive advantage 2) low-risk benefit ratio as only 2 of 16 instances of misrepresented publications were immediately appreciated 3) materiality associated with high median income 4) universality as "the perception may exist that it is the norm to inflate one's achievements on applications and this does not constitute an ethical problem 5) innocent error 6) visa status 7) mental aberration" (Sekas and Hutson 1995).
490. There were 150 program directors who responded for a perhaps limiting low response rate of 32% in this study (Grover, Dharamshi, and Goveja 2001).
491. "Deception—the active misrepresentation or omission of facts about one's qualifications, background, or abilities" (Grover, Dharamshi, and Goveja 2001: 444). In order, the most cases of recognized deception involved personal statement (339), letters of recommendation (88), graduation from qualified medical school (80), prior academic experience (30), National Boards Step 2 (29), National Boards Step 1 (13), ECFMG certification (12), licensure (5), dean's Letter (2), volunteer experience (2), research/publication experience (1), National Boards Step 3 (1), and malpractice history (0) (Grover, Dharamshi, and Goveja 2001: 444).
492. "During the initial review of gastroenterology fellowship applicants, only 2 of the 16 cases of misrepresentation were detected. These were recognized by flaws in the misrepresentation. In the first case, the applicant cited several papers on diverse subjects, all published during the applicant's first and second years of postgraduate training. The unusual diversity and productivity during this training period brought attention to his application. It was then noticed that one citation included a journal volume number that did not exist. Further

investigation revealed that three of the applicant's four "publications" were nonexistent articles cited in existing journals. In the second case, the applicant raised immediate suspicion by reporting the publication of a paper about a basic science topic in a purely clinical journal. Investigation showed that the article did not exist" (Sekas and Hutson 1995).

493. "In one study addressing this issue, the certification status of physicians in Yellow Pages advertising was misrepresented in 12% of all entries. Another study called attention to a 5% rate of falsified credentials in applications for employment in a large managed organization. In the past decade, the American Board of Internal Medicine (ABIM) and other certifying organizations have accumulated several dozen cases of fraudulent certificates that were presented by physicians seeking clinical privileges or employment by health care institutions" (Kimball 1995: 58).
494. "In order to have the best chance at obtaining a spot, students attempt to be perceived as the most desirable candidate for a particular program and discipline. In reality, applicants usually put together more than one application package, each of which is custom tailored to match the nature, requirements and goals of a given program or specialty. For example, applications sent to ophthalmology programs may reflect a candidate's true and primary desire to be an ophthalmologist, and the personal statements and letters of reference collected from staff ophthalmologists will also support this desire. Yet the application from the same student to his or her 'second-choice' specialty will make equally convincing arguments that the budding physician's primary and true desire is this second specialty. The personal statement will differ, as will the reference letters, which are now from staff in this second field. Honesty is never an issue—the emphasis is on avoiding failure and achieving success" (Young 1997: 220).
495. A review of 250 faculty applicant bibliographies from eight medical institutions, representing six medical specialties, revealed "systematic misrepresentation" among medical school faculty applicants (Goe, Herrera, and Mower 1998: 1186). They found 56 misrepresented citations among the 2,149 verified articles, which were spread out among 39 separate applicants (including 11 with two or more discrepancies) (Goe, Herrera, and Mower 1998: 1184). Of the 56 misrepresentations, 38 involved altering authorship order to enhance the applicant's position, 10 were citing a nonexistent article in an existing source, and 8 claimed authorship on an article that did not list the applicant as an author (Goe, Herrera, and Mower 1998: 1185). There were an additional 838 citations where the study authors could not locate the source material. There were 217 unverified citations (26%) among the 39 faculty bibliographies containing documented misrepresentation (an average of 5.6 unverified citations per author). The remaining 621 unverified citations were distributed among the 211 faculty applicants that did not have misrepresentations (an average of 2.9 unverified citations per author) (Goe, Herrera, and Mower 1998: 1185). In the discussion section of this article, the authors exhibit, even if they themselves do not articulate it as such, cognitive dissonance. Applicants for medical school faculty positions are often exquisitely sensitive to the nuances of the academic feeding chain. "Many of these discrepancies are likely to be due to intentional misrepresentations, as applicants, aware of the importance academia assigns to publication, attempt to gain competitive advantage by enhancing their bibliographies" (Goe, Herrera, and Mower 1998: 1185). While being cognizant of

the politics of “publish or perish,” the possibility is also raised that those who deceive may be just a little naïve: “Some of our observed discrepancies may reflect naiveté among applicants. They may rationalize that it is acceptable to pad resumes and misrepresent authorship order, while ignoring the ethical dilemmas associated with these practices” (Goe, Herrera, and Mower 1998: 1185). Potential faculty members are thus portrayed as sophisticated in their pragmatic recognition of what needs to be done in order to succeed but naïve in misapprehending deception as a short-cut or a means to a desired end. As with the residency and fellowship application misrepresentation, the take-home recommendation for “systematic representation” is vigilance at the individual level by “requiring applicants to document their bibliographic citations” (Goe, Herrera, and Mower 1998: 1186). This phenomenon is not framed as an invitation to examine the context in which these practices of deception proliferate.

496. The American Medical Association reported in 1997 that fees and tuition at medical schools in the United States have risen 400% for private and 250% for public institutions over the last 30 years (Woodworth, Chang, and Helmer 2000: 570). In addition to rising tuition and fees, other reasons for increasing debt burden of medical school graduates include increasing undergraduate debt and consumer debt (Elam et al. 2003).
497. Assuming a three-year residency and a 5% average interest rate, at the end of residency the average debt will be approximately \$120,000. American Medical Association, “Backgrounder on Student Debt,” accessed July 25, 2004 at: <http://www.ama-assn.org/ama/pub/category/9922.html>
498. American Medical Association, “Backgrounder on Student Debt,” accessed July 25, 2004 at: <http://www.ama-assn.org/ama/pub/category/9922.html>
499. “Despite the recent burgeoning of women in medicine, data for women are not presented here because the relatively few older women in the physician population falsely skew downward the mean age at physician death” (Frank, Biola, and Burnett 2000: 156). “To reduce confounding by gender or race/ethnicity, all analyses were gender-specific, and race/ethnicity-specific. Because of small numbers, we excluded from these analyses individuals of race/ethnicity other than white or black” (Frank, Biola, and Burnett 2000: 155). Rationales for examining this data by gender and race/ethnicity may be compelling. There is, however, an objection to be made is their title of “Mortality Rates and Causes Among US Physicians” when, in fact, it reflects only a specific sub-set that assumes norms of gender as male and race/ethnicity as dichotomous black or white. As Hawaii was one of the 28 states included in the data set, one can ponder the many doctors in this multi-cultural state who would not have met the criteria for inclusion. According to the Kaiser Family Foundation’s State Health Facts for Hawaii, in 2002, the percentage of female nonfederal physicians was 25%, while the percentage for the United States as a whole was 27% female. In 2002, the percentage of white nonfederal physicians was 31.4% and the percentage of black nonfederal physicians was 1.0% for Hawaii. The national figures for 2002 were 49.4% and 2.6% for white and black nonfederal physicians respectively. (Accessed July 31, 2004, <http://www.statehealthfacts.org/>)

500. The international research on suicide and mental health issues among physicians seems especially rich in Denmark, Finland, Norway, and the United Kingdom. Consistent with the physician mortality and causes in the United States, overall mortality was lower for physicians than the general population among Danish doctors from 1973-1992. Both sexes, however, showed a standardized mortality ratio that was considerably increased for suicide, "in particular because of an increased number of suicides by poisoning." (1.6 for males, 95% C.I.:1.4-1.9; 1.7 for females, 95% C.I.: 1.1-2.5) (Juel, Mosbech, and Hansen 1999: 456). A trend of female physicians having a greater suicide risk than the general population is congruent with findings in England and Wales (Hawton et al. 2001). The issue of suicide by poisoning becomes even more astonishing if one considers the extent to which "accidental poisoning" may or may not be coded as suicide. A study of an historical cohort of 18,358 male and 2,168 female National Health Service consultants, for example, highlighted an increased risk of death from "accidental poisoning" (especially involving prescription drugs) in male physicians and of suicide in female physicians (Carpenter, Swerdlow, and Fear 1997). Hypotheses to explain physician suicide advanced in the biomedical literature include psychiatric diagnosis (especially affective disorders, alcoholism, and substance abuse), "the stresses of practicing medicine," unrealistic expectations, role conflict, lack of professional support, inadequate psychiatric treatment of physicians, personality characteristics, and "psychosocial factors" (Frank and Dingle 1999: 1888).
501. "The proportion of doctors and other health professionals showing above threshold levels of stress has stayed remarkably constant at around 28%, whether the studies are cross sectional or longitudinal, compared with around 18% in the general working population" (Firth-Cozens 2003: 670).
502. A postal questionnaire completed by 286 general practitioners from two west London Health Authorities (51.4% response rate) concluded: "...anecdotal evidence suggests that doctors may not practice what they preach. The present study empirically tested this possibility and indicates that doctors consistently report that they would accept different treatment options for themselves than they would offer to their patients. In particular, whilst GPs may be prepared to cross the boundary and be treated the same as their patients if the symptoms are relatively uncontroversial, stigmatised problems and those with clinical guidelines may result in a 'do as I say not as I do' approach to health care" (Gardner and Ogden In press: 4).
503. Burnout has been more fully described as a "psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment. Over the past 20 years, many aspects of medical practice have changed: autonomy is declining, the status of physicians has diminished, and work pressures are increasing" (Linzer et al. 2001: 170). A comparison between 1,824 physicians in the U.S. Physician Worklife Study and 1,435 physicians in the Dutch Motivation in Medical Consultants Study found that physicians in the United States had a 22% prevalence of burnout contrasted with only 11% in the Dutch sample (Linzer et al. 2001: 171). "For both countries, work control was correlated with job stress and satisfaction, whereas work-home interference was associated with work hours, children, stress, (dis)satisfaction, and burnout...Male U.S. physicians described significantly more work control than

female U.S. physicians, a sex difference not seen in the Netherlands" (Linzer et al. 2001: 172-173).

504. A not-so-uncommon sentiment expressed by a second-year obstetrical resident in Florida in the late 1980's was: "What worries us most is AIDS. We're scared to death about it and talk about it all the time. We have very high rate of AIDS-infected women. Six percent of the Haitian mothers are infected with the AIDS virus, and when you deliver a baby, coming in contact with blood is unavoidable...(describes a fellow resident who sustained a needle-stick)...Besides being very frightened, he's very angry about the fact that we're risking our lives to take care of these patients (Pekkanen 1988: 7).
505. "But AIDS seems to have changed the balance for many who might have tolerated or welcomed the opportunities to care for the underserved. For a medical student contemplating a residency, what was previously a chance to gain relative autonomy quickly in an institution with many substance-abusing patients may have become predominately unwelcome exposure to a dreadful illness. If this is so, AIDS will trigger, in yet another way, a dreadful decline in the availability and quality of care for America's medical underclass" (Bosk and Frader 1990: 230).
506. The distinction between a turf of an unwanted patient and a legitimate referral in the best interests of the patient may be contested. "In a case last year, the 1<sup>st</sup> U.S. Circuit Court of Appeals held that an obstetrician did not discriminate against a pregnant HIV-positive patient when he decided not to continue her prenatal care or to deliver her child, and instead referred her to an HIV specialist. The obstetrician argued that he did not have the expertise in treating an HIV pregnancy; the former patient argued that an HIV specialist was not necessary. Both submitted testimony from experts. The Court of Appeals held that if there is room for a reasonable difference in medical judgment as to what is best for the *patient*, then it is not appropriate for the courts to get involved. On the other hand, if a doctor's judgment that a patient needs an HIV specialist lacks any reasonable medical basis, then the doctor may be liable for discrimination. The court explained that a refusal to treat would be discriminatory if the doctor's explanation was so unreasonable that it was a pretext for discrimination or if the doctor was relying on unreasonable stereotypes about persons with disabilities" (Albert 2002).
507. SARS is a droplet-spread illness that emerged from China in November 2002 and spread across the globe in a few weeks. Worldwide, there were about 8,500 persons diagnosed with probable cases of SARS and over 900 deaths. As of August 2003, there were 438 probable and suspected cases of SARS in Canada, including 44 deaths. More than 100 health care workers in Canada became ill with SARS and three died (National Advisory Committee on SARS and Public Health 2003: 1). There were reports of "this terrible panic that has seized Toronto" and worries that "panic is slowly replacing logic as SARS worries spread" even as SARS was mainly restricted to hospital settings (Canadian Press 2003). One reason for this spread in the hospital setting was attributed to exhaled droplets exiting from vents of oxygen masks that were often needed by the patients with SARS. One laboratory recreation, that allowed visualization of vapor expelled from the masks, showed "plumes of droplets that extended for five meters and beyond on each side of the mask-wearer" (Branswell 2004). The

original article in *Chest* reveals research that consisted of taking photographs of one subject demonstrating the use of three oxygen masks three times. Two of the masks had side vents for exhaled gas (one nonrebreathing mask and one Venturi-type mask) and the third mask had no vents and was shown with and without a respiratory filter (Hi-Ox80) (Somogyi et al. 2004). This demonstration was done by a team at University Hospital Network, funded by a grant from the Ontario Thoracic Society, and was completed under the direction of an anesthesiologist, Dr. Joseph Fisher (Branswell 2004). Just to complete the web between academia, government, organized medicine, and industry, "Dr. Fisher and Mssrs. Vesely, Somogyi, and Preiss participated in the development of the Hi-Ox80 and receive royalties on sales" (Somogyi et al. 2004: 1155). True to globalization's reach, the holder of the patent and the manufacturer of Hi-Ox80 is Viasys of Yorba Linda, California. These evaluators and patent-holders conclude: "In light of reports of SARS patients infecting other patients and health-care workers during the pre-intubation phase of their treatment, despite the use of protective equipment by health-care workers, we think that additional measures should be considered. The administration of oxygen using the delivery systems described in this article may further reduce the risk of the nosocomial transmission of respiratory infections such as SARS" (Somogyi et al. 2004: 1157). A small retrospective cohort study of 43 nurses who worked in two Toronto critical care units found the probability of SARS infection was 6% per shift worked. Assisting during intubation, suctioning before intubation, and manipulating the oxygen mask were found to be high risk activities (Loeb et al. 2004: 251). Juxtaposing these two studies confirms that there is an urgent need to find ways of ameliorating occupational transmission, which probably includes decreasing transmission from oxygen masks. This important topic would be better served by more rigorous scholarship than the proprietary infomercial found in *Chest*.

508. To take but one illustration from Kikwit's Ebola outbreak: "On March 2 Pauline Kabala...checked into Kitwit Maternity Hospital No. 2 suffering bloody diarrhea and vomiting blood. Eight nurses and several friends attended to Kabala, who was dying; within days all of them came down with same bloody illness. Six of the eight hospital employees died of it March. Before they died—indeed before they even realized that they were ill—these nurses and friends passed their infections on to still more hospital employees, family members and patients, starting a chain of death that would in April spiral out of the maternity hospital and into the general community" (Garrett 2000: 66).
509. In less than a week in September of 1994, 500,000 residents fled from Surat, Gujarat State, India in response to an outbreak of pneumonic plague. This city had 137 private doctors. "The private doctors panicked. Eighty percent of them fled the city, closing their clinics and hospitals and abandoning their patients" (Garrett 2000: 27).
510. "There is pandemonium at some hospitals where workers are staying home, said a doctor familiar with the situation who did not want to be identified." It was reported that "some hospitals in Vietnam and Hong Kong are working with half the usual staff, raising fears that inadequate care will contribute to further spread of the disease" (Altman 2003).

511. Laurie Garrett describes Ebola as “a mortal pestilence that passed from one human to another through acts of kindness and love” (Garrett 2000: 52). This hemorrhagic fever was a nosocomial disaster due to “poor hospital hygiene” (Garrett 2000: 89). “In the villages, where the only medical care available were the ministrations of friends and relatives, Ebola failed to pass beyond its initial chain of infection. But in Kikwit, where public health was a shambles, but medical clinics abounded, the virus would find grand opportunity” (Garrett 2000: 83). Although some staff did quit or threatened to quit or were described as “hysterical” (Garrett 2000: 75), it is the devotion of the health care workers, families, and neighbors that is so remarkable in these accounts of this epidemic. The Centers for Diseases Control and the World Health Organization reported 296 people died of Ebola during the Kikwit outbreak, and 79% of all identified infections had proved lethal. One third of the dead were health care workers (Garrett 2000: 98).
512. “One thing medical training does is smash your ideals and take away your niceness as a person. The hours that you work, the years of deprivation, being treated by a piece of dirt by everyone, being put under all this stress and pressure and nobody cares, and nothing thinks of you as a human being. You become an automaton doing things for the big guys. I know a lot of really good people who came out of their training being not as good or as caring as when they went in. All the years of deprivation makes some of them reach a point where they come into their own and think they deserve all they get. I’ve seen that happen to people, and when it does, there’s no charity anymore” (Pekkanen 1988: 15).
513. This title is a variation on the often used “doing better and feeling worse” phrase from Aaron Wildavsky’s essay “Doing Better and Feeling Worse: The Political Pathology of Health Policy.” He asked: “If most people are healthier today than people like themselves have ever been, and if access to medical care is now more evenly distributed among rich and poor, why is there said to be a crisis in medical care that requires a massive change? If the bulk of the population is satisfied with the care it is getting, why is there so much pressure in government for change? Why, in brief, are we doing better and feeling worse?” (Wildavsky 1977: 106).
514. For this U.S. Census Bureau document, “earnings is the sum of wage and salary income and self-employment income” (Weinberg 2004: 1). This report calculated the number of all year-round, full-time civilian workers to be 82,977,5000, of which physicians and surgeons are 515,500 (Weinberg 2004: 16).
515. Progress in the gap between the wages of men and women is often supported by the increase from 60 cents to the dollar female to male comparison in the 1960’s. A study by the Institute for Women’s Policy, however, shows that when the unit of analysis goes over 15 years, women earn only 38 percent of what men earn. That data set ended in 1998; when they looked at the 15 years prior to that, women earned even less, about 29 percent (Conan 2004).
516. (Bureau of Labor Statistics 2004) data is cited with a note indicating that its primary source is from a report from the Medical Group Management Association. This organization, founded in 1926, “is the nation’s principal voice for medical group practice. MGMA’s 19,000 members manage and lead 11,500



organizations in which approximately 237,000 physicians practice. MGMA leads the profession and assists members through information, education, networking, and advocacy." Website access June 5, 2004 <http://www.mgma.com/about/>

517. Total compensation for physicians reflects the amount reported as direct compensation for tax purposes, plus all voluntary salary reductions. Salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits were included in total compensation" (Bureau of Labor Statistics 2004).
518. "Total compensation for unincorporated physicians is earnings after tax-deductible expenses but before income taxes. For physicians in professional corporations it's the sum of salary, bonuses, and retirement/profit-sharing made on their behalf. All figures are medians. Data apply to individual office-based MDs and DOs" (Guglielmo 2003). This article also provides information on practice revenues for 2002 which range from \$780,000 for invasive cardiologists to \$249,000 for general practitioners, with a median of \$390,000 for all respondents (Guglielmo 2003). Physicians working in groups of 10 to 24 had the highest practice revenues (\$700,000) and total compensation (\$300,000). Geography also made a difference: physicians working in the South had the highest compensation as they typically earned \$30,000 more than their colleagues in the East (Guglielmo 2003).
519. Academic primary care physicians: \$131,926  
Private practice primary care physicians \$153,231  
Academic specialists \$175,000  
Private practice specialists \$274,639  
All data is for 2002 using Medical Group Management Association sources. Earnings for private practice physicians typically consist of gross revenues minus overhead. For academic physicians, earnings reflect straight salary and bonuses where applicable. Figures do not include benefits (Weiss 2003b: 56).
520. This Census 2000 report also calculated measures of earnings dispersal by showing the ratio of the value at the 90<sup>th</sup> percentile of earnings to that at the 10<sup>th</sup> percentile. The higher the values of the P90/10, the more dispersed are the earnings in that particular occupation. The P90/10 for all year-round, full-time workers was 5.00 (meaning the earnings at the 90<sup>th</sup> percentile are five times the earnings of the 10<sup>th</sup> percentile). In contrast to occupations where earnings are most similar such as postal service clerks (P90/10 of 1.89), occupational therapists (P90/10 of 2.13), or registered nurses (P90/10 of 2.41), physicians and surgeons have a P90/10 of 8.57 (Weinberg 2004: 17).
521. Data from Table 7.3 is taken from (BMJ Survey: Why Are Doctors So Unhappy? 2001). Final results had 1540 respondents, of which 1396 were categorized as "medically qualified doctors," 49 were medical students, and 54 were academic researchers. People were asked to pick 3-4 reasons that you think apply to the question: "why are doctors unhappy?" Table 7.3 included only the responses from physicians and the formatting was modified from the original to reflect a descending order of frequency for physicians' responses. This online survey was conducted from May 4-17, 2001.
522. David Morris's project is to help his readers recognize that "we are more than bundles of neurons"(1991: 289). His logic is as follows: "First: that chronic pain

constitutes an immense, invisible crisis at the center of contemporary life. Second: that traditional Western medicine—by which I mean not so much individual doctors and researchers as an entire scientific-medical worldview that permeates our culture—has consistently led us to misinterpret pain as no more than a sensation, a symptom, a problem in biochemistry. Third: that our present crisis is in large part a dilemma created and sustained by the failures this traditional medical reading of pain. Fourth: that by taking back responsibility for who we understand pain we can recover the power to alleviate it” (Morris 1991: 5).

523. As the “code blue” metaphor of immanent death requiring urgent intervention suggests in the title, this book is filled with the language of crisis. “The health care system is faltering, on the verge of collapse” (Annis 1993: 3) while Medicare and tort liability are both described as being “in crisis” (Annis 1993: 5).
524. Although happiness is “widely presumed to be positive,” there is a “burgeoning new science of happiness” that suggests happiness has a darker side. “As the British psychologist Richard P. Bentall has observed, “There is consistent evidence that happy people overestimate their control over environmental events (often to the point of perceiving completely random events as subject to their will), give unrealistically positive evaluations of their own achievements, believe that others share their unrealistic opinions about themselves and show a general lack of evenhandedness when comparing themselves to others.” Indeed, Bentall has proposed that happiness be classified as a psychiatric disorder.” Another strike against happiness is recent psychological research that finds “the happier your mood, the more liable you are to make bigoted judgments” such as relying on malicious stereotypes (Holt 2004). This *New York Times* article provides not only a vivid example of medicalization, with its description of happiness as a psychiatric disorder, but it also may provoke a reexamination of happiness as a dominant criteria by which a good life is weighed.
525. “Bill Gates and Paul Allen, the cofounders of Microsoft, together with Berkshire-Hathaway’s Warren Buffett, had a 1999 net worth larger than the combined GDP of the 41 poorest nations and their 550 million people” (Phillips 2002: 148).
526. According to *Forbes*, the three highest paid chief executive officers in 2004 were as follows: Reuben Mark, Colgate-Palmolive, \$148 million; George Davis, United Technologies, \$70.5 million; and Richard Fuld, Lehman Bros Holdings, \$67.7 million. Accessed September 5, 2004:  
<http://www.forbes.com/2004/04/21/04ceoland.html>
527. Some of the most highly paid celebrities in 2004 include: Mel Gibson and Oprah Winfrey, \$210 million each; J.K. Rowling \$147 million; Steven Spielberg \$75 million; Bruce Springsteen \$64 million; Tom Cruise \$45 million; David Letterman \$40 million, and Johnny Depp, \$28 million.  
Accessed September 5, 2004  
<http://www.forbes.com/2004/06/16/celebs04land.html>
528. In 2004, the five highest paid athletes were: Tiger Woods, golf, \$80.3 million; Michael Schumacher, race car driving, \$80.0 million; Peyton Manning, football, \$42.0 million; Michael Jordan, basketball, retired, \$35 million; and Shaquille O’Neal, basketball, \$31.9 million. *Forbes* points out that in 2004, “overall, the 50

highest earners pulled in a combined \$1.1 billion, 40% of which came from endorsements. The minimum to make the list was \$15 million versus less than \$5 million in 1994.” Accessed September 5, 2004:  
<http://www.forbes.com/celebrities/2004/06/23/04athletesland.html>

529. “For \$6,000 per family, or \$3,800 for individuals, not including doctors’ fees, cardholders in the Southampton PLUS plan are entitled to ‘priority access’ medical care at the hospital from May 28 to September 26” (Gaines 2004).
530. “Ballet Theatre, with its top-name dancers and moneyed, polite patrons, emphasizes restraint and distance. But other companies take a less-hands off approach, promising patrons the chance to become chums with distant figures of unnatural grace. ‘Don’t know what to get the person who has everything?’ the Nashville Ballet’s Web site asks. ‘Give them a unique gift of a dancer... They will be the envy of their friends and relatives alike when their dancer hosts a special reception and presents them with an autographed picture’ “ (Kinetz 2004). John Welker, a dancer with the Atlanta Ballet, was auctioned off for \$3,000 to Lynda Courts. Welker “plans to give Ms. Courts backstage tours, cook her dinner and send her birthday gifts. He said he would never refuse an invitation from her. ‘She is really a cornerstone of this community,’ he said. ‘I would definitely rotate my schedule to accommodate anything.’ He added, ‘To be quite frank, they are paying your salary.’ The sponsorship, he said, does bring pressure—but only to become a better artist. ‘In a way, she’s investing in a product,’ he said. ‘And you’re that product’” (Kinetz 2004).
531. The Southampton Hospital PLUS plan motto is “Peace of mind, all summer long.” The brochure for this program explains that “PLUS members are pre-registered, which includes being met at the door of the hospital, ‘by a member of the hospital’s senior staff.’ The brochure confides, ‘You shouldn’t have to wait around where your health is concerned,’ and adds, ‘While we can’t guarantee you’ll be seen first we’ll do everything possible to get you in and out fast.’ The plan covers not only family members, but also weekend house guests and ‘hired help’” (Gaines 2004).
532. “Americans did not suddenly become greedy. The aspirational gap has been created by structural changes—such as the decline of community and social connections, the intensification of inequality, the growing role of mass media, and heightened penalties for failing in the labor market. Upscaling is mainly defensive, and has both psychological and practical dimensions” (Schor 1999: 4).
533. This metaphor of “cooling the mark out” is from (Goffman 1952).
534. **Exhibit 8.2 Workforce Implications of Health Sector Reform\***

Objective/Proposed Changes	Workforce Implications
Efficiency/Decentralization	Decision power and authority transferred. Transfer of personnel administration and budget
Efficiency/Outsourcing, Privatization	Changes in contracts and working conditions New institutional arrangements, threat to the power of trade unions

Equity	Geographical and public/private redeployment New recruitment and retention mechanisms
Quality, user's satisfaction	Changes in the qualifications/skills/attitudes needed New work configuration (ex. Teamwork) Balance of power between health personnel and users changed

\*Source: (Rigoli and Dussault 2003: 4)

535. Physicians' associations are an example of political elites that are of significance for their potential to influence health sector reform. Other political elites that are of interest in this context include federal, state, and provincial officials, hospital associations, insurers, employers, and for-profit companies selling services (Lavis 2002).
536. Although framed in the language of population health, these are, of course, familiar themes to social medicine authors such as Rudolf Virchow discussed in Chapter Two or critics of capitalist health care such as (Navarro 1976; Waitzkin 1983). The point in starting the discussion here is that the discourse of health inequalities is timely. "The whole issue of health disparities is very hot now," said Nancy Adler, a professor of medical psychology at the University of California, San Francisco. "There is a meeting every other minute" (Cohen 2004).
537. In the developed world "there is some minimum level of income (around \$5,000 per capita in 1990) above which the absolute standard of living ceases to have much impact on health" (Wilkinson 1999: 37).
538. These trends on the applicant pool for United States medical schools are confirmed by more recent studies. "The percentage of women applicants increased from 20% of the pool in 1974 to 45% of the pool in 1999, while the percentage of men dropped from 80% to 55%. The number of underrepresented minority applicants (URM) increased 45% during the period, from 2,890 to 4,181 but, URM applicants represented only 11% of the total applicant pool in 1999. Between 1974 and 1999, the number of URM men applying to medical school dropped by 18%, from 1,984 to 1,629, while the number of URM women nearly tripled, from 906 to 2,552. The number of Asian/Pacific Islander applicants increased dramatically, from 986 in 1974 to 7,622 in 1999, and they now represent a fifth of all applicants" (Hall et al. 2001). Declining applicants to medical school along with a perceived growing need for physicians has renewed interest in this topic. "Inadequate finances deflect high school and college graduates from the paths that lead to medical education. These factors weigh most heavily on black and Hispanic children, particularly boys, but are prevalent among whites, as well" (Cooper 2003). It is also fascinating that the same dilemmas concerning the tension between access and quality described in Chapter Three resurface in the current literature. "Could the applicant pool be enlarged sufficiently to increase qualified applicants? Would medical schools be able to accommodate this increase in students? The impact of these increases could be an ultimate decrease in the quality of health care and the production of physicians who are not current with research findings, particularly in the area of genetics" (Wood 2003).
539. An international example that suggests similar dynamics might be "in the Soviet Union the average earnings of physicians are reported to be less than three-

quarters of the average industrial wage. Not coincidentally, 70 percent of the doctors are women" (Starr 1982: 6).

540. The illustrations of this are legion in popular culture but one favorite exchange that follows is between the fictional character Bernie Rhodenbarr and a cabbie in New York City:  
"There's not too much I can do," I said. "According to my doctor."  
"Doctors!" he cried, and spent the rest of the ride telling me what was wrong with the medical profession, which was almost everything. They didn't know anything, they didn't care about you, they caused more troubles than they cured, they charged the earth, and when you didn't get better they blamed you for it. "And after they blind you and cripple you, so that you got no choice but to sue them, where do you have to go? To a lawyer! And that's worse!" (Block 1995: 2)
541. Michael Crichton, MD (1942- ) is the creator of the television series ER and author of *Congo*, *Jurassic Park*, *Timeline*, *The Andromeda Strain*, *Five Patients*, etc.
542. Andrew Abbott suggests that "degradation can arise either through degradation of the work (and status) of given individual professions or through the recruitment of new professionals to positions embodying the degraded work" (1988: 127). Feminization and class change are both given as illustrations of recruitment changes (Abbott 1988: 128).
543. Stereotypes, of course, may be alternatively understood as accurate reflections of the lived realities of the patients as they experience the medical system. This thread comes out as the authors explain the disparity in their findings of no significant racial/ethnic differences in satisfaction levels and perceptions of physicians compared with other studies. "One reason for the disparity between our results and others may be the overall low-income level of the respondents in our studies. Individuals with low SES may feel marginalized by the health care system, regardless of their race/ethnicity. These patients' stereotypes of physicians may more strongly reflect their experiences navigating the health care system as individuals with low incomes and/or members of a stigmatized group (e.g. persons with HIV) than as members of a particular racial/ethnic group" (Bogart et al. 2004: 1056).
544. Reported rates of physician turnover vary widely (Misra-Herbert, Kay, and Stoller 2004). In a cohort of 533 postresident, nonfederal, employed primary care physicians younger than 45 years of age who participated in surveys in 1987 and 1991, 55% had left the practice in which they were had been employed once, and 20% had left two employers in the same time period (Buchbinder et al. 1999: 1431). While the cumulative effect in millions of dollars per year being spent on physician turnover rather than on patient care is of concern, other substantial consequences of turnover include effects on patient satisfaction, institutional public relations, and "effects on the organization or practice as a whole, related to the experiences of other health care providers" (Misra-Herbert, Kay, and Stoller 2004: 56).
545. "Organizations able to extract these high penalties for exit are the most traditional human groups, such as the family, the tribe, the religious community, and the nation, as well as such more modern inventions as the gang and the totalitarian party" (Hirschman 1970: 96). While leaving the yakuza or the mafia might have a higher exit price of two shots to the head than say, a cardiologist

calling it quits, the dynamics of self-identification with medicine might lead to ennui or alienation akin to that precipitated by a family feud, religious schism, or involuntary expatriation.

546. Socrates-Thrasymachus: "It will be better that I should ask you a question: Is the physician, taken in that strict sense of which you are speaking, a healer of the sick or a maker of money? And remember that I am now speaking of the true physician. A healer of the sick, he replied" (Plato 360 B.C.E.).
547. A news release issued by the Center for Health System Change to coincide with (Reed, Cunningham, and Stoddard 2001)'s report included the following statement: "Policy makers should take note that an important part of the safety net—physician charity care—is in danger of fraying," said Paul B. Ginsburg, Ph.D., president of HSC, a nonpartisan policy research organization funded solely by The Robert Wood Johnson Foundation. "If insurance costs continue to rise rapidly and the number of physicians providing charity care declines, access to care for the poor and uninsured will be in jeopardy" (Center for Study Health System Change 2001).
548. The total number of patient care physicians increased by 16,000 between 1996-1997 and 1998-1999 while the number of providers who provided any charity care declined by 4,000 in the same time period. The average number of hours of charity care provided per month was 11.1 in 1996-1997 and 10.6 in 1998-1999 (Reed, Cunningham, and Stoddard 2001: 2).
549. " In 1989 nearly one-quarter of all pediatricians would not see Medicaid patients, and an additional 30 percent limited the number they would see. In the state of New York in 1990, less than a quarter of the 43,000 practicing physicians would see Medicaid patients" (Weiss 1997: 181-182). These trends continue in the 21<sup>st</sup> century as "physicians technically participate in Medicaid and SCHIP but reportedly restrict caseloads to existing patients or agree to see a limited number of publicly insured patients each month" (Felland, Felt-Lisk, and McHugh 2004: 2).
550. "Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. HSC researchers interviewed individuals in each community who are involved directly or indirectly in providing safety net services to low-income people, including representatives of safety net hospitals, provider groups, community health centers, local health departments and government officials, academics and advocates" (Felland, Felt-Lisk, and McHugh 2004: 1).
551. "Physicians typically cite low reimbursement rates, higher risk of malpractice suits, and excessive paperwork as the reasons they refuse to see or limit Medicaid patients. States have tried to encourage physicians to take Medicaid patients by substantially raising Medicaid rates, but with generally poor results" (Weiss 1997: 182).

552. "In order to justify the boycott against Medicaid beneficiaries, physicians frequently invoke the stereotype of Medicaid patients who are overly eager to sue for medical malpractice and of juries who are overly sympathetic to the plaintiff and see the physician as having conveniently deep pockets. Although this stereotype makes effective propaganda and feels morally righteous, it is completely false. In the larger picture only two of every hundred victims of medical malpractice resulting in serious adverse medical consequences ever institute legal action, and only one of those victims of medical malpractice wins the suit. According to a comprehensive study by the GAO, compensation for fatal or injurious malpractice is even more unlikely for Medicaid and Medicare patients" (Weiss 1997: 182).
553. This premium increase was announced by Dr. Mark McClellan, administrator of the Medicare program, "late Friday afternoon, just as much of official Washington was heading out for a three-day weekend and the Republican convention and a hurricane moving toward Florida were dominating the news." Representative Pete Stark "scoffed at Dr. McClellan's explanation for the announcement's timing and said, "This is a cynical attempt to bury bad news by leaking it out when you hope no one is watching" (Harris 2004).
554. A *Medscape Money & Medicine* article that asks "Should You Consider Opting out of Medicare?" points out the "the price" of exit in this context; physicians derived nearly 30% of their 1997 income from Medicare. With that in mind, physicians with practices with a high percentage of privately insured patients or those specializing in procedures considered not medically necessary were posited as viable candidates for opting-out of Medicare (Cascardo 2003).
555. "The whole thing is so audacious that I have trouble controlling myself," said Dr. Harvey A. Zarem, the president of the California Society of Plastic Surgeons (and occasional guest surgeon on "Extreme Makeover" on ABC). "That anyone would even pretend to want to do this is just, just, just, I mean, it's offensive, incredible. Did I say absolutely audacious?" (Kuczynski 2004).
556. A fascinating account of "Sibling Rivalry: The Intraprofessional 'Turf War' Over Cosmetic Surgery" may be found in (Sullivan 2001: 102-130).
557. The notion of professions jostling each other to advance their professional projects is from Andrew Abbott (1988).
558. Dr. Jack Lewin, chief executive of the California Medical Association, "said that the key issue is, indeed, financial. 'We think this particular proposal is all about the money and not about improving health care,' Dr. Lewin said. 'Look. There are dentists out there who have gone through the full residency training to become plastic surgeons and we support their involvement here. But this becomes an area in which it's too easy to go after noninsurance money. We don't believe it improves quality of care. We believe it would go in the other direction'" (Kuczynski 2004).
559. Dr. Larry Moore, an oral surgeon who testified before the California Legislature on the bill, explains as follows: "Let's say you are in a horrible accident and half of your face is torn off," said Dr. Moore in an interview. "I can reattach it and then do all the follow-up surgeries to make sure it looks perfect. But I can't do that if you're born with an imperfect face. I can go in and reattach someone's

nose in the middle of the night. But if somebody came in and their nose had grown that way, we are prohibited from doing the same thing. That isn't fair" (Kuczynski 2004).

560. *Plastic and Reconstructive Surgery* is the "official organ of the American Association of Plastic Surgeons, American Society for Aesthetic Plastic Surgery, Inc. and the American Society of Maxillofacial Surgeons" according to the Hawaii Medical Library/Hawaii Voyager catalogue at <http://hml.lib.hawaii.edu/>.
561. A broader consideration of generating demand may be found in scholarship looking at the advertising industry. Illustrative works are (Kilbourne 1999) and (Ewen 1988; Ewen and Ewen 1997; Ewen 2001).
562. "Jews began the trend with nose operations before the end of the nineteenth century in reaction to strong anti-Semitic sentiment in Europe and North America. Other white minorities with stereotyped noses expanded the scope of surgical change. Asian Americans, who make up an average of 3 percent of plastic surgeon's cosmetic patients, restructure eyelids and noses and enlarge breasts. African Americans, who make up an average of 3 percent of plastic surgeon's cosmetic patients, restructure lips and noses" (Sullivan 2001: 65).
563. "Technological imperialism" is from (Sullivan 2001: 67).
564. "Some surgeons acknowledge that once you begin 'correcting' for age, it's all too easy to start sliding down the slope of habituation. 'Plastic surgery sharpens your eyesight,' said one. 'You get something done, suddenly you're looking in the mirror every five minutes—at imperfections nobody else can see'" (Bordo 1997: 45). One of my favorite exchanges is between a journalist who goes to Dr. Gerald Pitman, "an Upper East Side plastic surgeon who wrote the standard medical textbook on liposuction and aesthetic surgery," for a consultation. "When I ask whether he thinks cosmetic surgery is addictive, he stares at me as if I were obtuse. "Is alcohol addictive," he replies; it is an assertion, not a question (Merkin 2004).
565. Fox's *The Swan*, for example, follows 16 women "with eggshell egos" (Green and Lipton 2004: 59) for seven weeks as they go through the process of transformation and then adds a beauty pageant competition at the end to test those egos. Some medical colleagues wondered "why 13 of the contestants needed breast enhancements and 16 got brow lifts—a procedure not usually done on younger patients. ("They had brow droop," retorts (Dr.) Haworth.) (Green and Lipton 2004: 62).
566. A two-page survey "developed to assess the current practice environment of aesthetic surgery" was mailed to all members of the American Society for Aesthetic Plastic Surgery in November of 1998 (Krieger and Shaw 1999: 2305). A total of 632 surveys were returned out of 1180 surveys mailed (54.5 percent response rate) (Krieger and Shaw 1999: 2306). Results of percentage of practice revenue from aesthetic surgery were as follows: less than 25%--5.9%; 25-50%--21.3%; 51-75%--24.5%; and 76-100%--47.4% (Krieger and Shaw 1999: 2307).



567. In comparison with the 424% increase in number of cosmetic procedures performed by American Society of Plastic Surgeons from 1992 to 2003, the number of reconstructive plastic surgery procedures increased only 34% from 1,125,232 to 1,666,379 in the same time period (ASPS 2004). The top five reconstructive plastic surgery procedures in 2003 were tumor removal, hand surgery, laceration repair, breast reduction, and breast reconstruction (ASPS 2004).
568. This seems ironic in that the objection of these proponents of the market is not that government is too big but that it pays too little for their services. Their critique of current regulations is that they are insufficient to ensure a preferential market and income for them. This may be contrasted with Milton Friedman's view that "liberal principles do not justify licensure even in medicine and that in practice the results of state licensure in medicine have been undesirable" (Friedman 1962: 138).
569. The reality that plastic surgeons are doing as well as their peers and better than other professions is discounted in this framework by anticipating that the situation may change in the future. "For now, plastic surgeons seem to be doing as well as other medical specialties, and certainly are doing well when compared with other professions. However, economic and political realities indicate that there likely will be a continuing trend toward declining fees in both reconstructive and cosmetic surgery" (Krieger and Lee 2004).
570. Paul Starr notes that in mid-nineteenth century America a physician's standing was determined by his family background and the status of his patients rather than on the nature of medicine as an occupation (1982: 81). "The doctor in America was more a courtier than an autocrat" (Starr 1982: 80). William Osler, the "great American doctor" who was also claimed by Britain and Canada, routinely made house or hotel calls like other physicians of his era. When Osler was at Johns Hopkins in Baltimore he would go "practically anywhere else that a railway or carriage would take him" (Bliss 1999: 259). Osler would treat family and friends in Montreal and Toronto, politicians in Washington, and any case that interested him from the eastern seaboard to as far west as Wisconsin and Iowa.
571. "The concept started in Seattle around 1996, when Dr. Howard Maron launched MD2, a luxury personalized practice concept in which fees were set at \$10,000 to \$25,000 per patient per year. MD2 was like living with a doctor--the practice was limited to 50 patients annually" (Evans 2002a). "Maron said he got the idea while traveling as the team doctor for the Seattle Supersonics. He noticed the athletes got VIP care while the rich team owners struggled with the frustrations of traditional health care. 'I thought, Isn't it ironic that a player can get a response like that, while the wealthy and the powerful have to sit in ER waiting rooms as if they are a nobody—or an everybody?' Maron says" (Linn 2001). Maron desanctifies his work and puts it into economic perspective: "Maron says he's never run a charitable practice. 'None of these doctors is Mother Theresa,' he said. 'We're not saints. We're just practicing medicine.' At his peak, Maron says he was seeing 20 to 30 patients a day from a roster of 4,000. Now he has fewer than 100 patients and he may see one or two a day. In addition, his salary has increased considerably" (Linn 2001). The clientele of MD2 are described as "heads of large corporations with a very large net worth." They are "movers and

shakers who are very busy and don't want to wait to see a doctor" (Romano and Benko 2001). On their website, MD2's tagline is: "first and foremost in retainer-based healthcare." On the webpage that gives information for patients, the analogy between medicine and legal services implicit in the "retainer" descriptor is made explicit: "Furthermore, the physician, serving as a private advisor, will stand between the patient and the complex and intimidating medical world. This physician is 'reserved' as a medical expert for the family, much as a private legal counsel guides some families or corporations through the legal process. The physician ultimately becomes an indispensable ally and confidant—an integral part of the patient's life. (A personal physician who is not beholden to managed-care obligations is ideally suited to serve as your advocate and sponsor in the ever evolving health care reform climate.)" MD2 starts its message for physicians with a reminder of crisis: "As the American Healthcare system continues to unravel, physician frustration has reached epic proportions. Physician income, quality and patient-physician relationships are increasingly threatened." MD2 promises that their "unique model of retainer-based primary care stands to change this course. We have a sound business concept which supports the practice of a more thoughtful medicine, a more complete medicine, a more satisfying medicine." MD2's "ultimate goal is to create an international network of the best primary care physicians who share MD2's high standards of excellence in order for our patients to receive the best care and service—almost anywhere. We are looking for physicians like us who, by virtue of their reputations, have earned the privilege of moving into a new, exciting and rewarding phase of their career."

Accessed August 10, 2004 <http://www.md2.com/md2.html>

572. In some practices enrollment or membership fees must be paid in addition to whatever insurance premiums and fees are required as part of patients' health insurance plans while in other practices (that typically charge over \$10,000 per year) only membership fees are accepted as payment (Smith 2003). "Some doctors say "boutique" is just a new term for an old concept: refusing to accept insurance" (Colliver 2003).
573. One Denver internist, Robert Gleser generates 40% of his practice's revenue from alternative medicine treatments. He had a feng shui consultant do his waiting room as the idea is to "give them what they pay for" (Slomski 2000). As Maureen Swan says, "...it will have to be Nordstrom quality service for people to pay \$6,000 or more. And you can't have these patients sitting in the same office with the same old magazines and with kids sneezing on them" (Slomski 2000).
574. "Corporate clients for teaching hospital-based executive health programs include tobacco companies, organizations with extensive histories of environmental pollution, and health insurers (whose own policies increasingly limit the coverage of sick individuals)" (Donohoe 2004: 91).
575. Martin Donohoe points out a difficulty with this logic: "Luxury primary care clinics cater to the 'busy executive' who 'demands only the best' from his physician. Many of my patients, who work two jobs on an hourly pay scale and must find child care each time they return for another diagnostic test or subspecialty consultation, would be offended by these clinics' promotional materials, which imply that high-level executives are busier and lead more hectic

lives than other patients and thus require same day services. In fact, it is the lower socioeconomic status workers/patients who have worse health outcomes and are in greater need of efficient, comprehensive health care" (Donohoe 2004: 91).

576. Dr. Bernard Kaminetsky, a Boca Raton, Florida internist also affiliated with MDVIP, argues, "I think it's a little bit of political fiction to suggest that medicine is not already tiered—of course it is...I'd also point out the private-school and public-school analogy. If you had a beloved teacher in a public school who suddenly announced, 'I'm not going to be here. I'm going across the street to the private school,' those kids have the opportunity to transfer to the private school" (Romano and Benko 2001). The weakness of this analogy and the greater context of inequality within which it is located is vividly illustrated by Princeton Professor of Economics and Public Affairs, Uwe Reinhardt: "By the standards of America's so-called system of 'justice,' for example, or of its system of education, the egalitarian standards observed by its health-care system actually are quite exemplary, with or without boutique medicine (which is faint praise, to be sure). There is not much equality before the American bar. To any American who sincerely believes that a child in low-income Trenton, New Jersey has anywhere near the educational and career opportunities enjoyed by a child in nearby upper-income Princeton, New Jersey I would like to sell, at a bargain price, my ocean-front property in Iowa" (Reinhardt 2002).
577. One patient, Ron Loberfeld, is willing to pay the \$7,500 per year for his family to follow his internist to Personal Physicians HealthCare because "people in the system in general are rushed and by and large treated like cattle" (Kowalczyk 2001). Charles Evan, another patient at Personal Physicians HealthCare in Boston, pays the fee out of "desperation." "For his entire life, Evan's 17-year-old son Josh has battled diabetes and a stomach disorder so debilitating the young man often vomits 20 times a day. 'We have the most expensive insurance we can find but it doesn't get us what we need, which is care...I felt my whole family needed it. When you have a child with a chronic illness, the whole family suffers whether they know it or not'" (Connolly 2002).
578. "This is a symptom the whole health care non-system is unraveling" said Mitchell Rabkin, CEO emeritus of Beth Israel Deaconess Medical Center in Boston (Connolly 2002).
579. "Dr. Sidney Wolfe, director of consumer organization Public Citizen's health research group in Washington, DC, said; "Boutique medicine is a predictable consequence of how badly our healthcare system is functioning" (Charatan 2002).
580. Referring to the rise of concierge medicine, the Associated Press (2002) reports: "It's rise is a 'wake-up call,' said Mark Rothstein, director of U of L's Institute for Bioethics, Health Policy and Law."
581. Another physician, Jacob Teitelbaum, charges \$5,800 for an initial four to five hour chronic fatigue syndrome examination and \$660 per hour for follow-up care. By seeing patients five days a month he is able to generate \$150,000 per year and the rest of the time he does research and teaching: "The research and teaching are my ways of giving back; these activities benefit hundreds of

thousands of indigent patients," he says. "Why should all the doctors practice at the lowest common denominator so no one gets adequate care?" (Slomski 2000).

582. For example: "Aetna is profitable again. The company's secret to success: cherry-picking healthy patients. According to the *New York Times*, Aetna has cut the number of people it insures to 14.4 million, from 22 million in 1998, and it expects to make further cutbacks. Becoming smaller has so far proven to be more profitable. Aetna is happy to see some of its customers go, because they were heavy users of medical services and had been costing Aetna money. The trick is not to drive away the profitable customers. 'If you don't raise your prices with surgical precision,' said a company spokesperson, 'you can chase away your healthy customers and be left with the sick people.' 'We're not interested in being the largest. We're just interested in being the best, and most profitable,' said CEO Dr. John W. Rowe" (Hellander 2003: 844).
583. "We've seen a declining percentage of physicians who are accepting new patients, either Medicare or privately insured," says Paul Ginsburg, president of the Washington-based Center for Studying Health System Change. "If concierge medicine becomes very popular and starts involving a significant number of physicians, this could lead to a decline in access for the rest of the population" (Baker 2002).
584. A common theme in the mass media accounts of boutique medicine is found in the following conclusion of a *Washington Post* article: "But rather than eliminate gold-plated medicine, the real solution, they suggest, is to provide that sort of care to everyone. 'You can make the argument that all adults should get this kind of checkup,' said Lauer. 'Why should it be restricted to executives and people who can pay?'" (Connolly 2002). The other side to the argument is that gold-plated medicine is inefficient, unnecessary, and may even be dangerous if closer proximity to the medical system provides more opportunity for iatrogenic mishaps. A Dr. Solomon from Boston makes the point that "catering to patients' unrealistic demands will drive an even bigger gap between levels of care. 'Not everyone needs to be seen the day they call,' he said. 'It's a total luxury'" (Wiebe 2002).
585. "Luxury primary care also undermines cross-subsidized care. For the past 50 years, the American health system has been dependent on cross-subsidies from patients with good insurance coverage to those with poor coverage or none. For example, a hospital manages to cover the costs of providing care for uninsured patients because it receives payments that exceed the costs of providing care for some well-insured patients. Physicians do the same" (Brennan 2002: 1167).
586. "Critics say such practices will create different levels of care for the haves and have-nots. Ellen Shaffer, an assistant professor at UCSF, described such practices as a "gated community for health care." "We're talking about carving out niches so only the wealthiest can afford this kind of care," she said (Colliver 2003).
587. "The new practice would end up being more about extravagant service for relatively wealthy people than about effective medical care. But Levine talks about it in tremendously idealistic terms. 'We'd do this kind of like a study,' he says. 'We could track stuff. Are our diabetics more under control? Do our patients with heart failure live longer than other patients with hear failure? And

if what we learned could be distributed, if I could prevent 2,000 strokes across the country instead of 2 in my practice, that'd be great. It's important to me to be a pioneer of health-care delivery. That's a sappy way of putting it, but that would make me feel good" (Friedman 2002). An innovative pilot program in Washington state that was designed to track and improve health outcomes for people with diabetes and congestive heart failure was recently reported to be a clinical success but it "raises doctors' ire" (Kolata 2004). Follow up by nurses and electronic records helped the patients: "But there is a catch. When as with the Whatcom County program, medical care is improved, and money saved, there are winners: in this case, insurers, including Medicare, which could save millions, and pharmaceutical companies. And there are losers: general practitioners and hospitals, with each doctor standing to lose at least \$2,000 a year, according to projections, and some doctors reporting that their costs are already much higher...The problem, said Dr. David Reuben, chief of the geriatrics division at the University of California, Los Angeles, medical school, is that 'we have a health care financing system where the incentives are totally misaligned.' 'Let's say you do a really good job of keeping somebody out of the hospital,' Dr. Reuben said. 'Or let's say you spare someone a physician's visit. You save the system money, but nobody benefits from the saving.' Or as Dr. Laine said: "The concern we had was that in a system that requires substantial investment, the benefits that accrue to the system need to accrue back to those making the investment. Unless that happens, the system is not credible and it is not sustainable" (Kolata 2004).

588. A *New York Times* article that presented "Dr. Levine's Dilemma" of whether he should join his mentor, Dr. Stephen Flier, at Personal Physicians HealthCare gave some of the reasons why Levine was seriously considering joining a boutique practice. Many of Levine's complaints reprise themes outlined in Chapter Seven as he longs that "my life should be the focus of my life:" "Here's how it works," Levine says. "A few years ago, managed care paid us, let's say, \$90 for a sore-throat visit. Now they pay us \$60. That means we'd have to see 30 percent more patients to make up that revenue. We're affiliated with a hospital, and the hospital loses money, and they need that revenue from us. And I wonder, Is this going to get more bleak? Am I going to have to see more patients? I'm good at it now because I'm young and I have energy. But I can't do this for another 30 years. You see doctors who leave the system after only a year or two because they can't take it. And a lot of doctors are giving care that's only adequate. They have no desire to be a great doctor. I never want to get that way.....I have no daylight hours left to do what I want. My son is 1 right now, and there are many days when I literally do not see him awake. I want my son to know me. As a physician, it's always been frowned upon to talk about those things. It's like, You're here to practice medicine, and it should be the major focus of your life. My life should be the focus of my life. My family comes first. My friends come first. And that's not how I'm living right now. I want to change that. And I don't think I should have to feel guilty about it" (Friedman 2002). The article ends without a clear decision being articulated. Jim Levine is not one of the three physicians pictured on the Personal Physicians HealthCare website as of August 10, 2004  
<http://www.personalphysicians.net/>

589. "While the exact number of academic medical centers sponsoring luxury primary care clinics is not known, the list includes many U.S. medical schools

and teaching hospitals, including such well-known institutions as Massachusetts General Hospital, Johns Hopkins, New York Presbyterian, University of Pennsylvania, University of California—San Francisco, Stanford, University of Miami, Vanderbilt, Wake Forest, Washington University, Emory, Georgetown, George Washington University, University of California—Irvine, Ohio State, Bowman Gray, Duke, Mayo Clinic, Northwestern, Cleveland Clinic, Oregon Health and Science University, Virginia Mason (affiliated with the University of Washington), Cedars-Sinai (affiliated with the University of California—Los Angeles), and others (Donohoe 2004: 90).

590. "They're carving out the cream of their own practice," said Dennis Brown, MD, a family physician from Schaumburg, Ill, and an AMA delegate" (Norbut 2003).
591. "The Dare Center in Seattle, for example, charges an annual fee of \$3,000. Each physician provides care for 200 to 300 patients (as compared with approximately 1200 to 1600 patients in many standard primary care practices). The resulting gross revenue per physician—approximately \$600,000—is greater than that in a highly efficient primary care practice with the requisite 4000 visits per year" (Brennan 2002: 1165).
592. "The physician did not admit wrongdoing, but he did agree to a \$53,400 fine and said he would not ask Medicare beneficiaries to pay an extra fee for the services he described in his contract" (Keeping It Ethical: Retainer Practices Have Rules and Restrictions 2004).
593. These guidelines affirmed individual choice and pluralism of financing even as they raised questions about whether this trend should be encouraged:  
"Individuals are free to select and supplement insurance for their health care on the basis of what appears to them to be an acceptable tradeoff between quality and cost. Retainer fees for special services and amenities, therefore, appear to be consistent with a system based on pluralistic means of financing and delivery of medical care. Whether this trend should be promoted is a question to which there is not yet a definite answer" (Council on Ethical and Judicial Affairs 2003: 4).
594. "Even after the council adopted this new, laissez-faire attitude toward boutique practices, however, it ran into opposition among the AMA house. The problem this time was the decision to include a reminder that physicians 'have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation.' Several delegates balked at this language because the ethics group used the word 'urgent'. Doctors, the critics charged, are only obligated to provide care in emergency, not urgent situations" (Peck 2003). AMA trustee, Dr. Ron Davis, said at a news conference "that if retainer practices did ever 'take over an area, that would be a concern for us and we would have to revisit this issue because it is possible that (retainer practices) could threaten access. We couldn't support anything that would threaten access to care'" (Peck 2003).
595. "The boutique practices are marketed in much the same way as luxury cars or first class plane tickets, so it is difficult to imagine they will meet this ethical litmus test. In fact, Dr. Leonard Morse, chairman of the ethics group, said the

council drafted the new policy without ever reviewing a retainer medical practice contract, so the council does not know what level of care is offered by the contract" (Peck 2003). The president-elect of the American Medical Association, Dr. John Nelson said, "If I want to have a separate contract with a patient for services and procedures not covered by insurance, I ought to have a right to do that. But it must be done in such a way that I'm not double-billing or double-charging" (Pear 2004b).

596. An additional conflict of interest concern is as follows: "Marketing for luxury primary care clinics is directed at the heads of successful small and large companies. In addition to obtaining full reimbursement for services (patients are responsible for what insurance does not cover), hospitals hope these high-level managers will steer their companies' lucrative health care contracts toward the institution and its providers. Some programs give discounted rates in exchange for a donation to the hospital" (Donohoe 2004: 91).
597. "Advocates of luxury primary care counter that they are simply filling a small niche. They point out that at the premium level required to be a true luxury practice, relatively few patients will be interested in paying for such care and that it thus does not pose a threat to health care access in general. Since professional ethics is a matter of reasoning on the basis of principles, there is something suspect about this argument. It suggests that in the current situation—that is, with relatively little demand for luxury primary care—the practice can be endorsed by professional ethics. However, if the demand were great and access were reduced, then the practice would be considered unethical. This means that the definition of ethical practices changes with the situation—in this case, the degree of access to health care. Such situational ethics flies in the face of standard professional principles" (Brennan 2002: 1167).
598. "Rewarding increased convenience with increased revenue in an amount chosen by recipients is widely practiced in the nonprofessional service industry as tipping (to ensure promptness); its resemblance to boutique medical practice suggests a degree of abasement unworthy of our profession" (Jones, McCullough, and Richman 2004: 1355).
599. "'Why be a slave to the insurance companies?' says Dr. Sarah Davis, one of the first so-called boutique doctors in the Dallas area... 'I'm offering a service for a fee—more time, less rush'" (Evans 2002a).
600. "Dr. Carroll, who said retainer practices tend to overlook patients with no choices, offers a cash practice mainly for people who make too much money to qualify for Medicaid but are otherwise uninsured. Patients can get up to 30 minutes with Dr. Carroll for \$60. Follow-up appointments for an acute condition, if they are within a week of the original appointment, are only \$10, and annual exams for women are either \$80 or \$100...Dr. Carroll said, 'The amenities offered can be offered a la carte, and a physician can still make a decent living'" (Norbut 2003).
601. This is a Robert Evans's argument that "private medicine and private insurance are symbiotic" (Evans 1999: 38). The threat here is once again similar to sustaining widespread community support, especially among the elite, for public education once private education is an attractive option for the affluent. Moving

back to a health example, Evans points out: "And people who rely primarily on private insurance become a constituency not for improvements but for further deterioration—if you do not use it why pay taxes for it?" (Evans 1999: 39).

602. "...the creative physician can invent numerous ways to game the system....Gaming does not begin until the physician pushes harder against a proper fit between language and reality. He may fudge, using florid description to exaggerate the seriousness of the patient's condition to a utilization review officer who has been reluctant to authorize hospitalization, or he or she might install an intravenous line in a patient who has no need for intravenous medication, solely to ensure such a utilization review authorization. There are many methods and degrees of fudging, short of outright lying, and many physicians have expressed willingness to resort to such tactics on occasion. At the extreme end, the stretch and push of fudging merges into the flagrant dishonesty of fraud" (Morreim 1991: 444).
603. "A random national sample of 1124 practicing physicians was surveyed by mail in 1998; the response rate was 64% (n = 720) (Wynia et al. 2000: 1858).
604. "Physicians do not have limitless time to advocate for their patients' interests. When their backs are against the wall, the easiest solution for some physicians may be to manipulate reimbursement rules" (Werner et al. 2002: 1138).
605. John Marquis is an attorney in Grand Rapids, Michigan who gives physicians advice on how to stay legal. "The easiest way to avoid getting in trouble with Medicare for charging an extra fee is to offer nonmedical services. For example, some doctors offer transportation or cell phone access. Physicians who simply send letters to their patients asking for an additional \$200 a year to offset lower revenues or higher liability premiums could run afoul of the prohibitions on added charges, he said. 'It's hard to justify that in a Medicare context because you're just asking everyone to pay more money,' Marguis said. 'That's not what concierge medicine is all about'" (Hawryluk 2004).
606. "A soloist who works with an NP and a part-time associate, Weisbrot has about 9,000 patients. About 60 percent are in fee-for-service HMOs, and nearly all the rest are on Medicare. After talking with a lawyer, Weisbrot decided not to charge administrative fees to Medicare patients. He sent letters to 4,000 households with commercial insurance, asking them to pay \$45 a year per individual or \$80 per family. Of the roughly 2,000 people who responded, 80 percent signed his agreement and sent him checks, and more are coming in. When a nonresponder visits the office, he's asked to pay the fee; 80 percent are doing so, Weisbrot says. By April, he'd collected \$65,000 in administrative fees. Payment of the annual charge is not mandatory, but the alternative is to pay a la carte for administrative services. These fees range from \$10 for filling out short forms and making long-distance calls when patients are out of town to \$40-\$50 for nonemergency after-hours phone consults, arranging for private nursing services, and appealing denied claims. 'Social visits' to patients in the hospital cost \$100" (Terry 2004).
607. Definitions of research misconduct used most often in the United States "cover sins of research design, review and publication, but do not address other ethical breaches, such as agreements with sponsors not to publish or forgo editorial control of the research data. The definitions also fail to include misconduct that



endangers the lives of human research participants” (Breen 2003: 188). A more exhaustive list includes the following published examples of research misconduct: “(i) putting patients in danger (via poor study design, inadequate research oversight, ignoring adverse events or failing to adhere to the approved protocol), (ii) engaging in fraud or deceit, (iii) fabricating or falsifying research findings, (iv) forging consent forms, (v) engaging in multiple publication, (vi) committing plagiarism, (vii) failing to inform or warn, (viii) failing to obtain consent, (ix) failing to report or delaying the report of research findings, (x) refusing to accept institutional or research ethics committee oversight, (xi) accepting confidentiality clauses regarding publication of findings (xii) accepting ‘gift’ authorship and (xiii) failure to declare interests” (Breen 2003: 188). Research misconduct has been linked to the following factors: “(i) increased academic expectations and increased need to publish, (ii) personal ambition, vanity and the desire for fame, (iii) laziness, (iv) greed linked to direct financial gain, (v) mental illness, (vi) messianic complex and (vii) lack of moral capacity to distinguish right from wrong” (Breen 2003: 189).

608. HealthSouth operates 4 medical centers, 209 surgery centers, 136 diagnostic centers, as well as 1,427 outpatient and 118 inpatient rehabilitation centers (Hellander 2003: 841).
609. “The fraud included \$2.5 billion in fraudulent accounting entries from 1996 to 2002, \$500 million in incorrect accounting for goodwill and other items involved in acquisitions from 1994 to 1999, and \$800 million to \$1.6 billion in ‘aggressive accounting’ from 1992 to March 2003, said Bryan P. Marsal, the company’s chief restructuring officer” (Freudenheim 2004).
610. When the United States attorney’s office in Birmingham, Alabama issued subpoenas for HealthSouth documents, Scrushy said in a written statement at the time, “As we have said before, we do not believe that HealthSouth or anyone associated with HealthSouth has done anything wrong” (Romano 2003).
611. A lawsuit filed on behalf of HealthSouth’s stock and bond investors “contends that Ernst & Young, HealthSouth’s former accounting firm, and UBS Warburg, its former investment banker, were aware of fraud at the company even as they signed its financial statements and sold HealthSouth securities to the public” (Morgenson and Abelson 2004).
612. “Frist has said in the past that he has no involvement in the business of HCA and that his holdings are in a blind trust. The foundation, however, wants the senator to explain why his position as leader of the Senate would not be at odds with his family’s ties with HCA. “HCI, HCA and your entire family stand to profit directly from the passage of malpractice caps legislation... You have used your prominent public position to be a primary advocate for medical liability caps,” the letter said. A spokesman for Frist said the Senate Select Committee on Ethics repeatedly has found the senator has no conflicts of interest” (Group Questions Frist’s HCA Ties Amid Debate Over Tort Reform 2003).
613. “Blue Cross of California, for example, found that it paid Tenet hospitals an average of \$15,213 per patient, 43 percent more than other California hospitals, and that “stop-loss” charges accounted for more than 50 percent of the total amount Blue Cross paid certain Tenet hospitals” (Hellander 2003: 842).

614. "Tenet and many other hospitals found their loophole in what Medicare terms 'outlier' payments, a kind of bonus payment to hospitals to cover patients whose care proves to be unusually expensive. Here's how it works: Every hospital maintains a charge master list -- a 'retail' price list for its procedures and products -- which it uses to negotiate fees with managed-care companies. But Medicare also uses the charges in calculating its 'outliers.' The agency knows that the charges are inflated, so each year it compares a hospital's charge list with the facility's actual cost reports, and then discounts. If a fictional Tenet hospital charges \$100 for pneumonia, but it actually costs the hospital \$50 on average to treat pneumonia, Medicare discounts 2-to-1 and uses this lower number to figure pneumonia outlier payments until the hospitals revise their price lists. But Medicare is a government bureaucracy that fell years behind on its ratio calculations. When Tenet raised its prices aggressively and quickly, Medicare's assumptions fast became obsolete. When the same fictional Tenet hospital raised its price for pneumonia treatment to \$300 from \$100 (even though it still only cost the hospital \$50), Medicare, using its old 2-to-1 discount, would figure the cost at \$150" (The Real Tenet Scandal 2002). "Tenet CEO Jeffrey Barbakow admits the firm had an 'aggressive pricing strategy.' By increasing Medicare's outlier payments, Tenet was able to triple its profits for the third quarter of 2002, to \$315 million—up from \$89 million in the third quarter of 2001" (Hellander 2003: 842).
615. "Normal checks and balances did not seem to apply to Dr. Moon, Redding physicians said. He was not only head of the cardiology program but also a hospital director. And though he was not board certified in cardiology or internal medicine — a credential he dismissed as insignificant — he was also head of the hospital's Cardiology Care Committee, in charge of conducting peer review of his own program's quality of care" (Eichenwald 2003a).
616. "Dr. Moon recommended that a patient, Mary Rosburg, receive immediate coronary surgery, according to papers obtained by federal investigators. A surgeon working with Dr. Realyvasquez telephoned Dr. Campbell, vehemently arguing that no surgery was needed. Dr. Moon's view prevailed, and the once-reluctant surgeon performed the operation. Ms. Rosburg died from complications several months later. In 1995, another of Dr. Campbell's patients, Emma Jean Montgomery, came under the care of Dr. Moon's team. An associate of Dr. Moon informed Dr. Campbell that the patient had severe coronary disease and needed immediate surgery, which Dr. Realyvasquez performed. Afterward, when Dr. Campbell reviewed the medical chart, he found none of the evidence of serious heart problems that Dr. Realyvasquez had described, according to records obtained by federal investigators. Dismayed, Dr. Campbell took Ms. Montgomery's records to another local cardiologist, Dr. Roy Ditchey, who was astounded to hear that the patient had undergone surgery, according to information obtained by federal investigators. It was then that Dr. Campbell approached Mr. Corbeil, but the administrator dismissed his concerns, papers obtained by the investigators say. Dr. Campbell, who still practices in Redding, has since filed a suit on behalf of the government, under the federal whistleblower statute, which remains under seal" (Eichenwald 2003a). The California Medical Board is investigating Moon for "fraud, gross negligence, dishonest or corrupt acts and incompetence" (Jaklevic 2003).

617. Tenet did organize a peer review when threatened with direct loss of revenue. Blue Cross of California informed Tenet of plans to terminate its contract based on "what it alleged were improper, medically unnecessary coronary-artery-bypass-graft procedures performed at the Doctors Medical Center of Modesto hospital. Blue Cross based its termination on a study of 23 cardiac-patient records from the hospital from Jan. 1, 2000, to Jan. 31, 2003...Tenet, Santa Barbara, Calif., said it commissioned a panel of cardiologists and cardiac surgeons not affiliated with the company or its hospitals. The panel found that all 23 patients had received appropriate treatment, Tenet said, adding that its reviewers saw the same patient charts and angiograms as the Blue Cross reviewers" (Business Brief: Tenet Healthcare Corp. 2003).
618. A Catholic priest, Rev. Joseph Corapri, was told he needed life-saving cardiac surgery that required immediate surgery. Corapri consulted his friend, Joseph Zerga, who persuaded him to have the surgery in Nevada. Doctors in Nevada informed Corapri that he did not have heart trouble. The two men confronted the administrators at Redding "who maintained that Father Corapri indeed had a heart problem." Zerga contacted the Federal Bureau of Investigations and then they subsequently filed a federal whistle-blower suit claiming that Redding was cheating Medicare under the False Claims Act. In January of 2004 Corapri and Zerga were awarded \$8.1 million from the government as a result of the whistle-blower suit (Eichenwald 2004).
619. "Tenet's problems are instead an example of what happens when the private market, which prices health care via actual demand and costs, runs headlong into Medicare's artificial world of regulations, price caps and coverage limits. Only when Medicare is reformed to respond to market incentives rather than to bureaucratic command and control will "frauds" like Tenet stop happening"(The Real Tenet Scandal 2002).
620. "The total cost of crimes by physicians against Medicaid is far from certain. When a figure is given, it tends to be 10% to 25% of the total program cost for the states and the federal government, which in 1991 is projected to exceed \$66 billion. No evidence that we have been able to locate, however, lends credence to either percentage" (Jesilow, Geis, and Pontell 1991: 3318).
621. Conventional wisdom, crystallized in a 1992 Government Accounting Office (GAO) Report, puts it at 10 percent (roughly \$100 billion per year). But the 10 percent figure has no basis in fact. The GAO report merely says, "Estimates vary widely on the losses resulting from fraud and abuse, but the most common is 10 percent..of our total health care spending." GAO got their estimate from "industry experts," and now "industry experts" get their estimates from GAO. The 10 percent estimate has been politically useful: high enough to be credible in the face of continuing media revelations about fraud and to justify the "get tough on fraud" rhetoric, yet low enough not to disturb the medical profession too much (Sparrow 1996: 2).
622. A physician billing for abortions on women who were not pregnant, included one who had had a hysterectomy. "In 48 separate instances, he billed Medicaid for performing two abortions within a month on the same patient" (Jesilow, Geis, and Pontell 1991: 3319).

623. "Physicians who are punished for Medicaid violations typically do not represent the mainstream of US medicine. They are marginal within the profession, not necessarily because of their abilities, but rather because of characteristics of their practices or of themselves. We located background information regarding 138 of the 147 physicians sanctioned for Medicaid fraud and abuse in the 5-year period between 1977 and 1982. Slightly more than one third had graduated from foreign medical schools; blacks and psychiatrists were also overrepresented" (Jesilow, Geis, and Pontell 1991: 3319). A survey was conducted by mail with a random sample of 1,124 physicians from the 1997 American Medical Association Masterfile. After excluding physicians of Canadian origin, they had a response rate of 64.6% (n =702) among 1,087 physicians. This study found that international medical graduates (IMG) were less likely than US-trained medical graduates (USMG) to use deceptive tactics in insurance billing and medical practices. "Overall we found no support for the hypothesis that IMGs were less ethical than USMGs...Our evidence presents an interesting contrast to the greater rate of fraud and abuse penalties experienced by IMGs" (Lee et al. 2004: 262).
624. The Office of Inspector General of the Department of Health and Human Services in 1989 reported that 12 percent of physicians billing Medicare have ownership or investment interests in entities to whom they might refer patients. A 1992 study in Florida found that at least 40 percent of physicians in that state who were involved in direct patient care had investments in a health care entity to which they might refer patients. Of those who had investments 91 percent were in specialties with the ability to refer patients for the services of that entity. Both studies believed these numbers to be underestimates because ownership arrangements are often complex with physicians owning part of a parent company, which is then listed as the actual owner of the health care entity. Thus, it was not always possible to identify the individual physician owners (Zientek 2003: 113).
625. Diagnostic services include "freestanding laboratories, diagnostic imaging centers (radiology, CT scanners, MRI, ultrasound), freestanding and mobile catheterization laboratories, and endoscopy centers" (Zientek 2003: 114).
626. Therapeutic services such as ambulatory surgical centers, minor emergency rooms, dialysis units, physical therapy or rehabilitation facilities and radiation therapy centers are also often targets of physician investment" (Zientek 2003: 114).
627. "The broad categories of argument encouraging physicians to invest in health care facilities or service providers include: financial benefit (both to the physician and community by reducing cost), quality, increased autonomy (in the way medicine can be practiced and the influence physicians can have within the organization), and community impact (availability of and access to services). Each of these areas can be seen as a benefit to patients or the community which should not be denied, or a conflict of interest which may induce physicians to pursue their own advantage over that of their patients" (Zientek 2003: 116).
628. "The first study looked at utilization of diagnostic imaging procedures for four presentations (respiratory symptoms, pregnancy, back pain, and difficult urination) and found that those who did not refer to outside radiologists used imaging 4 to 4.5 times as often as those referring outside their office. In addition,

self-referring physicians generally charged more for examinations, and this, combined with increased utilization led to mean imaging charges per episode of care 4.4 to 7.5 times higher than for those who used outside referral. A later study looking at ten clinical presentations confirmed that self-referring physicians utilized imaging procedures 1.7 to 7.7 times more frequently than those referring to a radiologist with a resultant increase in imaging charges per episode of 1.6 to 6.2 for self-referring physicians. Neither study had definitive data to conclude whether physicians using their own equipment were excessively utilizing procedures or if outside referring physicians were under-utilizing the procedures" (Zientek 2003: 117-118).

629. This is not to say that there has not been much discussion since the American Medical Association was founded on other topics of professional ethics such as kickbacks. "Fee-splitting" was the not uncommon practice "whereby a specialist, typically a surgeon, gave an under-the-table kickback to a general practitioner for referring a patient—without informing the patient of this transaction" (Stevens 1999: 79). "The American College of Surgeons has campaigned against kickbacks for almost a century. For, where kickbacks are permitted it is likely that many referrals go not to the most qualified surgeon but the one who is willing to share the largest percentage of his or her fee. The AMA has generally had in its code of ethics that kickbacks are unethical but have often stopped short of advocating severe punishment for the practice" (Stout and Warner 2003: 172).
630. "All the evidence points to the fact that physicians do not abuse their patients, that physician investment has been of considerable value in providing new technologies and facilities not otherwise available, and that patients wish to be free to pursue their physician's recommendations" (Todd and Horan 1989: 396).
631. "Whereas the legal profession has a long tradition of regulating lawyer conflicts of interest, the medical profession barely acknowledged the problem prior to the 1980's, when the federal government became interested in the financial arrangements between physicians and health care businesses. Even then, the American Medical Association (AMA) did not take a strong position on the issue until 1991, when it finally declared most self-referrals to ancillary facilities unethical. By then it was too late, as Congress had already set in motion the federal regulation of self-referrals of Medicare and Medicaid patients. Similarly, the AMA did not issue guidelines on conflicts of interest in clinical research until the late 1980's, after the federal government became actively involved in the area" (Moore 2003: 135).
632. "For instance, a policy statement formulated by the American College of Radiology in 1989 stated, 'the practice of self-referral of patients for a diagnostic or therapeutic medical procedure may not be in the best interests of the patient. Accordingly, referring physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients'" (McDowell 1989: 81-82).
633. "In February, there were 17 cardiac, 36 orthopedic, 22 surgical, and 17 women's hospitals that met our specialty hospital definition and were open for business" (General Accounting Office 2003: 5). This is a tripling from the 29 that existed in 1990. An additional 20 specialty hospitals are under development, most of which will specialize in surgical care (General Accounting Office 2003: 6).

634. "President and Chief Executive Officer James Elrod said Willis-Knighton's profits have dropped by two-thirds in the three years since at least five surgery centers, three imaging centers and an endoscopy center have opened. The hospital's net income shrank from \$30 million to about \$8 million, on annual revenue of about \$550 million in the fiscal year ending Sept. 30, 2002. 'There's no question that financially we have been impacted. I've referred to this as poaching of services,' Elrod said" (Reilly 2003).
635. "New research showing that specialty hospitals might be 'cherry-picking' their patients has renewed concerns that community hospitals may be stuck with the pits" (Hawryluk 2003). American Hospital Association executive vice president, Rick Pollard, argues, "niche providers cherry-pick the healthiest patients, leaving community hospitals to care for the sickest of the sick" (Hawryluk 2003).
636. "A federal law, known as the Stark anti-self-referral law, generally prohibits physicians from referring Medicare patients to facilities in which they (or their immediate family members) have financial interests... The Stark self-referral prohibitions do not apply in the case of specialty hospitals, however, because the law does not prohibit physicians who have ownership in an entire hospital from referring patients to that hospital. It is likely that any referral or decision made by a physician who has a stake in an entire general hospital would produce little economic gain because such hospitals tend to provide a diverse and large group of services. However, the Stark law does prohibit physicians who have an ownership interest only in a hospital subdivision from referring patients to that subdivision. Concern exists with respect to specialty hospitals, that since they are usually much smaller in size and scope than general hospitals and closer in size to hospital departments, that their physician owners could influence their hospitals'—and therefore their own—financial gain through practice patterns and referrals" (General Accounting Office 2003: 2). A legislative history of the Stark Amendments may be found in (Stout and Warner 2003).
637. Fewer than half of the specialty hospitals offer emergency care and specialty hospitals have worsened the shortage of specialist physicians willing to cover emergency rooms (Abelson 2003). Boutique hospitals undermine the social safety net by diverting resources away from the community hospitals: "We are the safety net," said Nancy Farber, chief executive of Washington Hospital Healthcare System in Fremont, Calif. "Our emergency room is the front door for people without insurance, the homeless, the underinsured," leaving the hospital with losses, she said (Abelson 2003).
638. Behaving badly by abusing trust afforded by one's role is certainly not limited to medicine as people who have been abused by nurses, teachers, lawyers, and clergy can attest. The physical and psychological intimacy that is a routine part of health care work with people who are often in particularly vulnerable situations makes misconduct by all health care workers particularly unsettling. While lawyers may have comparable opportunities to bill during episodes of professional misconduct, I would like to argue that this particular kind of episode exemplified by Dr. Smith is particularly egregious because of a constellation of abuse that combines rape and fraud while specifically legitimating sex as medical treatment. A lawyer may take advantage of a distraught client, have sex in the office, and charge that time as "billable hours"

but would find it difficult to argue to the client that this interlude would assist the pertinent legal project. Once again, while such misconduct is certainly not representative of the majority of physicians, it is important to give it serious consideration because the medical profession, like the Catholic Church, has shown institutional patterns of protecting perpetrators. The scandal with the Catholic Church goes beyond the 4 percent of Catholic priests who have been sexual abusers (Greeley 2004) to the persistence, even after sex abuse scandal was widely publicized in 2002, of moving hundreds of priests from the countries where they have been accused of abusing children to “start new lives in unsuspecting communities.” A year long investigation by the *Dallas Morning News* discovered that “the priests lead parishes, teach and continue to work in settings that bring them into contact with children, despite church claims to the contrary” (Associated Press 2004d). Although a hallmark of a profession is self-regulation, the Public Citizen’s Health Research Group presents credible evidence that the willingness and ability of the medical profession to discipline its membership varies widely. There was a 11.1 fold difference between the state with the most serious disciplinary actions by state medical boards in 2002, ranging from Wyoming at 11.87 serious actions per 1,000 physicians to Hawaii at 1.07 serious actions per 1,000 physicians (Public Citizen 2003). “If all the boards did as good a job as the lowest of the top five boards, the rate for #5, Oklahoma, being 7.56 serious disciplinary actions per 1,000 physicians or 0.756 percent, this would have amounted to a total of 6,089 (0.756 of 805,372 non-federal doctors) serious actions a year. This would be 3,225 more serious actions than the 2,864 that actually occurred in 2002” (Public Citizen 2003).

639. Dr. Randall J. Smith told a patient “having sex with him would ease her pelvic pain.” “Although Gresham police said the woman had the mental capacity of a 12-year-old, Hopkinson said that could not be proved beyond a reasonable doubt. ‘She has children of her own—she’s had consensual sex in the past,’ Hopkinson said. ‘If we had been able to prove that she was mentally incapacitated, then it would have been a sex crime.’” Once the Multomah County prosecutors agreed that existing Oregon statutes “did not provide a mechanism to prosecute Smith for a sex crime,” the case was referred to the Oregon Department of Justice’s Medicaid fraud unit. Smith will serve 60 days in jail, perform 200 hours of community service, be on probation for 18 months, and pay a fine of \$1,105 as part of a plea agreement. He voluntarily surrendered his medical license to the Oregon Board of Medical Examiners. The incidents occurred between October 2002 and December 2003. Smith told prosecutors that the sex was consensual but “never disputed billing the Oregon Health Plan for the time he spent during the 45-to-50-minute sessions.” Adventist Health, who employed Smith for 15 years, fired Smith and reimbursed the Oregon Health Plan back about \$5,000 to cover the costs of the claims (Tomlinson 2004). In a different case: “A psychiatrist charged Medicaid for sexual liaisons with a patient, claiming that he had submitted the bills for professional services so that his wife, who handled his books, would not become suspicious of his dalliance” (Jesilow, Geis, and Pontell 1991: 3319).
640. This interesting story in the *New York Times* examined visits to physicians as “a social activity” in Boca Raton, Florida. “Many patients have 8, 10 or 12 specialists and visit one or more of them most days of the week. They bring their spouses and plan their days around their appointments, going out to eat or shopping while they are in the area. They know what they want; they choose specialists

for every body part. And every visit, every procedure is covered by Medicare." One internist, Dr. Robert Colton said, "This Medicare card is like a gold card that lets you go to any doctor you want." As the private insurers in Florida pay the same or less than Medicare, physicians argue that they must see a high volume of patients to keep their practices viable. Colton said he was seeing as many as 35 patients a day and "I felt like a glorified triage nurse." Colton joined a boutique practice, MDVIP, which charges \$1,500 per year. Colton argues, "The system is broken. I'm not being a mean ogre, but when you give something away for free, there is nothing to keep utilization down. And as the doctor, you have nothing to gain by denying them what they want." One of the patients interviewed for this article saw things a bit differently: " 'The doctors are raping Medicare,' said Louis Ziegler...Ziegler recalled going to a doctor for a chronic problem, a finger that sometimes freezes. All he wanted was a short of cortisone. But he got much, much more. 'I had diathermy. I had ultrasound. I had a paraffin massage. I had \$600 worth of Medicare treatments to get my lousy \$35 shot of cortisone'" (Kolata 2003). Rather than blaming either patients or doctors for abusing the system, it is interesting that some of the factors that are driving this scenario are not discussed. For example, to what extent is the doctor shopping a function of fear that the physician who performed a cursory examination did not understand the patient's situation? How many doctor visits are generated to try to manage the iatrogenic side effects of multiple therapies prescribed by several physicians in an elderly patient population with increasingly fragile equilibriums? To what extent could the social needs of human contact, friendship, caring, seeing familiar people be fulfilled in other venues if society was organized to provide an increased amount of social support? How could medical care and reimbursement be changed so that health care workers have meaningful, interesting work and fair financial compensation?

641. See, for example, such dissertations as (Klover 1977; Sakmyster 1981; Julnes 1988; Wolff 1990; Thompson 2000b).
642. Advocacy by the Association of Internes and Medical Students for national health insurance and international collaboration provoked an investigation by the American Medical Association. "At the June 1948 AMA Convention, a resolution was accepted that described AIMS as a "sinister conspiracy." This resolution authorized the AMA investigation of AIMS based on the claim that the organization had "advocated the overthrow of the United States government by force and violence [and it] favors strikes upsetting to proper medical education" (Julnes 1988: 14). The president of the American Medical Association circulated an article from *Medical Economics* which labeled the Association of Internes and Medical Students as a "communist front" (Julnes 1988: 15). Although the investigation by the American Medical Association yielded no proof of communist affiliation, these charges, along with competition from the Student American Medical Association, brought about the demise of the Association of Internes and Medical Students in 1952 (Julnes 1988: 15; Wolff 1990: 31). The Student American Medical Association was founded in 1950 and was quite ideologically different from the Association of Internes and Medical Students. "The AMA, and therefore the SAMA, opposed, while AIMS favored, the elimination of racial discrimination in medicine, higher salaries for housestaff and for a national health insurance plan. SAMA had the full blessing and financial backing of the American Medical Association (AMA) and predictably



resulted in SAMA becoming the only surviving intern association" (Julnes 1988: 15).

643. "The purpose of the antitrust law is to promote competition among providers of goods and services as a way to enhance consumer welfare...In contrast, the purpose of labor laws is to keep human labor from being treated as a 'mere commodity,' and to permit collective agreements and action among workers to raise and standardize wages and improve working conditions. Strikes, boycotts, and other collective activity to raise wages are permitted and even favored by the labor laws to protect and enhance the economic power of the worker" (Hirshfeld 1999: 45).
644. See, for example, the case where the U.S. Department of Justice barred the Federation of Physicians and Dentists from acting as the collective bargaining agent for competing doctors. "In its complaint, the Justice Department alleged that the federation conspired with Delaware's orthopedic surgeons in 1996 and 1997 to jointly negotiate contracts with health insurers, in particular Delaware Blue Cross and Blue Shield, which covers 20% to 30% of Delaware's insured residents. The union attempted to sign up every orthopedic surgeon in the state 'because the federation will only be effective if every orthopedic group is in,' according to a letter cited in the suit" (Taylor 2001).
645. The National Labor Relations Board turned down the request to have the United Food and Commercial Workers represent the physicians. The executive director of the Federation of Physicians and Dentists, Jack Seddon, was quick to call the "UFCW's legal brief weak and hastily submitted" (Lowes 1998). About 1,000 independent physicians joined the International Association for Machinists and Aerospace Workers in northern New Jersey (Lowes 1998).
646. National Doctors Alliance is an umbrella group for three unions that together comprise 15,000 members. The three are the Committee of Interns and Residents, the Doctors Council, and United Salaried Physicians and Dentists. National Doctors Alliance is based in New York City (Preston 2000).
647. The Federation of Physicians and Dentists is based in Tallahassee, Florida and has 8,500 physician members (Preston 2000).
648. The Union of American Physicians and Dentists has about 5,500 members, 80% of whom practice in California (Preston 2000).
649. "The Office and Professional Employees International Union's physician organization, the National Guild for Medical Professionals, signs up doctors in private practice only, and does so only through medical societies. While OPEIU does represent physicians in collective bargaining, its focus is legislative" (Preston 2000).
650. The acronym for Physicians for Responsible Negotiation (PRN) is a salute to the Latin, *pro re nata*, meaning "take as needed," used as a common abbreviation on prescriptions.
651. Of course, once the first blush wore off, Weinmann did not hesitate to let potential union members know which union would not serve their interests well

in his view: "PRN is an employers' union where the so-called union is already in bed with the employers," said Weinmann...."It will not have to have real labor lawyers because they won't have to know how to deal with strikes" (Thompson 2000a).

652. With a subsection title of "Just Don't Use the U-Word," explains: "...talk of union solidarity is a hard sell for many physicians. The word 'union,' with all its baggage, hurts their ears as much as the word 'taxes.' ...Doctors who support collective bargaining often substitute the word "guild" for union. Or they say they're not forming a 'traditional' union, a clear reference to the AFL-CIO" (Lowes 1998: 122).
653. On March 10, 2004, the AMA issued a brief statement on their website that said "recently, the AMA and PRN mutually agree that PRN should operate as an entirely independent organization with no connection to the AMA." The brief statement of March 10, 2004, attributed to Michael Maves, "AMA Separation from PRN," may be found at: <http://www.ama-assn.org/ama/pub/article/1617-8441.html>  
Unlike the full-page ads when PRN was launched, "news of the PRN's situation was never publicly announced or acknowledged by the AMA. The AMA did not comment, aside from the March 10 statement" (Romano 2004).  
Although there was speculation that PRN might affiliate with the Service Employees International Union (Romano 2004), as of August 21, 2004 the PRN website just describes PRN as "the only national, independent labor organization created specifically for physicians." Basic information about PRN may be found at <http://www.4prn.org/about.html>. Although the website mentions that "PRN was created by the AMA to empower physicians in today's challenging environment," no acknowledgement of their altered status is made on the PRN website. Their last press release is dated June 3, 2003 on the theme of "PRN retained by Society of Practitioners of the Columbia Presbyterian Medical Center" at <http://www.4prn.org/pr.html>.
654. One of the reasons that emotions ran so high in the Saskatchewan physicians' strike was the death of nine month old Carl Derhousoff on the first day of the strike, July 1, 1962: "On the night of June 30 the Derhousoffs, suddenly realizing their baby was seriously ill, raced eighty-five miles seeking help. The parents first drove the twenty-two miles of gravel to the town of Preeceville, but the Preeceville doctors had left....The Derhousoffs then drove thirty two miles to Canora, normally a busy four-doctor town. It had been decided not to provide Canora with emergency services, and there were no doctors at the hospital there. In desperation they then drove thirty-one miles to Yorkton. The baby died during the trip" (Badgley and Wolfe 1967: 61).
655. It is fascinating to note that in articles that have one or more physicians listed as authors, the time period of the strike tends to be described as "4 months" (Ron et al. 1985; Bukovsky et al. 1985). Articles written from a social science perspective tend to describe the time period of the strike as "118 days," which sounds much longer (Pilpel, Naggan, and Sarov 1985; Barnoon, Carmel, and Zalzman 1987).
656. "Medical liability reform is AMA's No. 1 legislative priority." Main page of the American Medical Association, accessed August 24, 2004  
<http://www.ama-assn.org/>

657. Main page of the American Medical Association, accessed August 24, 2004  
<http://www.ama-assn.org/>
658. "Skyrocketing medical liability premiums--\$200,000 a year or more in some high-risk specialties—are forcing physicians to limit services, retire early, or move to a state with reforms where premiums are more stable." Accessed August 24, 2004  
<http://www.ama-assn.org/ama/pub/category/7861.html>  
 "Premiums are rising fastest in specialties like internal medicine, general surgery and obstetrics and gynecology, which have each had average increases nationally of 30 percent to 40 percent over the last two years, says the newsletter *Medical Liability Monitor*, which tracks the malpractice insurance industry. In Miami, some obstetricians now pay more than \$200,000 a year for malpractice insurance, compared with a national average of \$56,546 (Oppel 2003).
659. Note that even the web address for Doctors for Medical Liability Reform is strategic <http://www.protectpatientsnow.org/>
660. The extent of this crisis was contested in a *New York Times* op-ed article entitled "Cooking Up a Crisis," in which Bob Herbert (2004) pointed that "in several states specifically characterized by the AMA as in 'crisis,' the evidence is rolling in that malpractice claims and awards are not appreciably increasing, and in some instance are declining." One of the states that the American Medical Association has marked red on its crisis map is Missouri. "But a press release in April from the Missouri Department of Insurance said, 'Missouri medical practice claims, filed and paid, fell to all-time lows in 2003 while insurers enjoyed a cash-flow windfall.' Another red state on the AMA map is New Jersey. Earlier this month, over the furious objections of physicians' representatives, a judge ordered the release of data showing how much was being paid out to satisfy malpractice claims. The judge's order was in response to a suit by the Bergen Record. The newspaper reported that an analysis of the data showed that malpractice payments in New Jersey had declined by 21 percent from 2001 to 2003. But malpractice insurance premiums surged over the same period. AMA officials told me yesterday that they thought the New Jersey data was 'incomplete,' but they did not dispute the 21 percent figure. Last summer a legislative committee in Florida, another red state, put insurance executives, lawyers and medical lobbyists under oath in an effort to get to the truth about malpractice costs. When questioned about frivolous lawsuits arose, Sandra Mortham, the chief executive of the Florida Medical Association, told the panel, 'I don't feel that I have the information to say whether or not there are frivolous lawsuits in the state of Florida'" (Herbert 2004).
661. "American Medical Society President Dr. Robert Rigolosi said New Jersey doctors mobilized after Gov. James E. McGreevey failed to mention the malpractice problem in his State of the State address. "The governor's omission convinced the rank and file physician community that the governor and certain other leaders in Trenton have not recognized the magnitude of this health-care crisis,' Rigolosi said. 'The flames for a job action spread like wildfire'" (McAleer 2003). A different framing reads: "Here's what physicians want: caps on noneconomic damages ("pain and suffering") of \$250,000, a shorter statute of limitations, and stringent requirements for expert witnesses" (Weiss 2003a: 27).

662. Scripted Message Provided by the Medical Society of New Jersey for physicians' answering machine on February 3, 2003 obtained from their website: "Starting February 3 until \_\_\_\_\_, our practice will close its doors to participate in the statewide physician job action. We apologize for any inconvenience this may cause you or your family. Please be assured that our participation in this job action is necessary to preserve the future of our medical practice and of all health care in New Jersey. Without effective medical liability reform, our practice may have to close its doors in the near future. If you would like to support physicians and the future of healthcare in New Jersey, please call 1-877-KEEP MDS. The operator will help connect you to your local legislators and the governor's office. Tell them that the medical liability system needs to be fixed according to the guidelines offered by the Medical Society of New Jersey and the New Jersey Hospital Association. We have been here in the past and would like to continue as your physician(s). In the event of an emergency, we urge you to contact our service at \_\_\_\_\_ or go to your nearest emergency room for treatment. Thank you for your patience."
663. "Physicians recorded special phone messages, or told their staffs to instruct patients to go to the ED. They handed out leaflets to patients to explain the job action, gave them form letters to send to their legislators, and circulated petitions. Organizers created a Web site ([www.njpatients.org](http://www.njpatients.org)), and a special hotline to allow patients to voice their support. (By May, the legislators would receive 35,000 letters and more than 15,000 phone calls.) (Weiss 2003a: 28).
664. "He asked me who I worked for and then asked me who my father was," Kimberly Banks told The Associated Press. "I told him (State Rep.) Earle Banks. He told me, 'I can't see you because your father is against tort reform'" (Babwin 2004).
665. "One couple was put on the list after winner \$40.9 million over a botched operation by a drug-dependent surgeon" (Blumenthal 2004).
666. "There's no question that physicians are totally frustrated by the relentless assault on the medical profession by trial lawyers," said Dr. William G. Plested, chairman of the A.M.A.'s board of trustees and a cardiovascular surgeon in Santa Monica, Calif. Dr. Plested said the government already maintained a database of doctors who had been sued, for use by medical professionals. "Is it fair to come to me if you've sued the last 10 physicians you've seen and never collected?" he asked. "Is it fair for me not to know that?" (Blumenthal 2004)
667. The Texas Medical Association referred questions about the group to its general counsel, Rocky Wilcox, who responded in a short statement: "We are not a part of and, in fact, don't even know who is running this service. The fact that it exists testifies to the continued frustration physicians feel as they try to care for their patients amidst the epidemic of lawsuit abuse." (Blumenthal 2004)
668. Membership includes the following: Neurosurgeons to Preserve Health Care Access, American Association of Orthopaedic Surgeons, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Surgeons Professional Association, Society of Thoracic Surgeons, American College of Cardiology, American Academy of Dermatology Association, National Association of Spine Specialists, American Urological

Association, and the American Society of Plastic Surgeons. Doctors for Medical Liability Reform website, accessed August 24, 2004  
<http://www.protectpatientsnow.org/aboutdmlr.html>

669. Doctors for Medical Liability Reform website, accessed August 24, 2004  
<http://www.protectpatientsnow.org/aboutdmlr.html>
670. In the summer of 1993 the AMA reported 275,510 members. When those who paid nominal dues or those who are except from paying dues (medical students, residents, military doctors, retirees) are subtracted, the remainder was 153,268 members, 24 percent of American doctors, who paid full annual dues (Wolinsky and Brune 1994: 6). In 2004 the American Medical Association's website indicates a membership of "250,000 and medical students." The 90 percent membership figure was obtained by including the American Medical Association's federation of medical specialty organizations, which Wolinsky and Brune argue is an attempt to boost "its prestige before Congress and the public." "But this is a desperate move by an association that cannot compel doctors to become members and has considerable difficulty persuading them to join voluntarily. The different specialty groups often are warring factions whose own agendas and policies may not coincide with those of the AMA's" (Wolinsky and Brune 1994: 6). American Medical Association website, accessed August 25, 2004,  
<http://www.ama-assn.org/ama/pub/category/12014.html>
671. "Fortune magazine ranked the American Medical Association higher than any other medical or health care organization in its survey of Washington's 25 most powerful lobbying groups. The *National Journal* ranked the AMA's Political Action Committee one of the most powerful political action committees—and the highest-ranked health care-related political action committee. Washington's *Roll Call* magazine calls the AMA "one of the most powerful advocacy organizations in the nation." American Medical Association website, accessed August 25, 2004:  
<http://www.ama-assn.org/ama/pub/category/12014.html>
672. The top ten "blue chip investors" in order of dollar amount since 1989 are as follows: American Federation of State, County & Municipal Employees, National Association of Realtors, National Education Association, Association of Trial Lawyers of America, Communication Workers of America, Service Employees International Union, International Brotherhood of Electrical Workers, Carpenters & Joiners Union, Teamsters Union, and American Medical Association. Center for Responsive Politics, accessed August 25, 2004:  
<http://www.opensecrets.org/orgs/index.asp>
673. The Center for Responsive Politics notes on methodology: "the numbers on this page are based on contributions from PACs, soft money donors, and individuals giving \$200 or more...In many cases, the organizations themselves did not donate, rather the money came from the organization's PAC, its individual members or employees or owners, and those individual's immediate families. Organization totals include subsidiaries and affiliates. [For the year 2004] all donations took place during the 2003-2004 election cycle and were released by the Federal Election Commission by the Federal Elections Commission on Monday, July 05, 2004. Website accessed August 25, 2004:  
<http://www.opensecrets.org/industries/contrib.asp?Ind=H01&Cycle=2004>

674. "Indoctrinologists" are activists whose "prescriptions for cure are ideology and social reform" (Satel 2000: 6).
675. Sally Satel is a writer who criticizes Michel Foucault without engaging with his ideas directly as she complains that postmodernism has become "an ideological staple in the humanities, fine art and social studies" (Satel 2000: 11). She also does the equivalent of an edited sound bite when she writes: "I am by no means the first to describe this worldview. The medical economist Robert G. Evans comments in his 1994 book *Why Are Some People Healthy and Others Not?* that, 'for those on the left, health differentials are markers for social inequality and injustice more generally, and further evidence of the need to redistribute wealth and power, and restructure or overturn the existing social order'" (Satel 2000: 11). Satel does not point out that the context of this statement is: "For some (on the right), 'the poor ye have always with ye.' One can never remove social differentiation; some people are just better than others, and some will always remain at the bottom. Health differentials are thus inevitable (and probably deserved). 'What can't be cured, must be endured.' Fortunately most of us have the intestinal fortitude to bear with good grace the suffering of someone else." Then Evans writes as above on the left, and then Evans makes his main point which Satel completely misses: "Both preconceptions miss the main point of Marmot's findings, that there is *something* that powerfully influences health and that is correlated with hierarchy per se" (Evans 1994: 6).
676. Satel explicitly writes "my goal is not to defend the status quo" (Satel 2000: 6). Her main argument, however, is exactly in support of the status quo for the following reasons. "First, the upstream conditions targeted by indoctrinologists (such as income inequality) correlate with, but do not necessarily *cause*, ill health. Indeed, inferences about the causal pathways to a disease become less and less secure the further upstream one looks for the root cause—thus, there is no guarantee that social revisions they seek would even improve health. Second, abstract proposals for attaining social justice have vast repercussions for other sectors of society. Unlike discrete vaccination programs and cancer screening campaigns, active prescriptions for social restructuring are intended to go far beyond the confines of a health care agenda. Third, there is much we can do by ourselves to safeguard our own health through diet, exercise, safe sex and so on" (Satel 2000: 15).
677. Dr. Sam Bierstock practiced ophthalmology for about 15 years in New York "before a shoulder injury forced him out of surgery and into consulting" (Jackson 2001). He sings and plays the harmonica within the band.
678. Sample tunes and other song titles may be heard at:  
[http://www.managedmusic.com/cd\\_goin-bare.htm](http://www.managedmusic.com/cd_goin-bare.htm)
679. "The hardest thing is staying ahead of the curve of absurdity. We'll joke about one thing then we'll see it in *The Wall Street Journal* a week later," said Dr. LaGana, 60, who works as a staff physician in New Jersey for Merck and Schering-Plough" (Adams 2004).
680. They perform an average of seven or eight shows per year--to national groups for \$10,000 and state groups for \$6,000 (Adams 2004). The website for Damaged Care has the lyrics written out for such songs as "Doctors in Cyberspace,"

"That's Cost Containment," "Mergemaker," "The Spare Part Blues," and "Health Care Business" at <http://www.damagedcare.com/lyrics.html>

681. The *Placebo Journal* website is <http://placebojournal.com/>. An one year subscription is \$24.00 for 6 issues. The June 2004 issue contains "True Stories of Medicine" submitted by readers, short blurbs such as "Why I Hate Being on Call" and "Malaprop Corner From a Chart Reviewer and Coding Specialist," and "X-Rays Files" showing films such as a bullet to the scrotum ("the guy's story was that he was an innocent bystander") and smiley face cancer ("that's what you get if you smoke") (X-Ray Files 2004).
682. "The Placebo Gazette" is an email newsletter that first circulated on January 29, 2004. It comes out approximately once every two weeks and is archived at: <http://placebojournal.com/Placebo%20Gazette.htm> In Placebo Gazette #1, it was explained "with a newsletter I feel I can be a little more political" (Farrago 2004g). Doug Farrago explicitly views the Placebo Gazette as "a chance to talk about politics of which the health care system is very much a part"(2004f).
683. In the "Posters for Office" section of the Placebo Journal website, there are eight 18" x 24" posters on sale for \$11 each. Many are fake drug ads such as Oycotton Candy, Godivaphage, Cyanara, Myagra, and Nordart, one is "Diary of a New Drug Rep," and two are algorithms—one for hyponatremia and one for upper respiratory infection.  
<http://placebojournal.com/Posters%20Special!.htm>
684. The Nordart poster illustrates this mean-spiritedness. The text reads: "With Nordart™, the physician becomes a trained blower who can now shoot his patient in the buttocks as they head out the door. It's easy! It's fun! Just like shooting spitballs, Nordart™ comes with its own specially designed straw with medicine preloaded right in the barrel. One hit gives the patient an appropriate dose of progesterone that will last a full three months." This dart contraception, of course, is directed to female patients as the text asks: "How many times have you seen patients who refuse the shots, forget their pills or steer clear from IUDs?" "Nordart™ is especially targeted to your most non-compliant patients." "A great way for doctors to enjoy contraception" but "PJ Pharmaceuticals does not claim physicians should decide who should have children or not. Far be it for us to judge." <http://placebojournal.com/Nordart.jpg>
685. "For those who want Canada's socialized healthcare system to be adopted here, let me give you some information from the front lines. I just saw a patient who moved recently from Canada to Maine. She got right in to see me for her issues. During our visit I asked her about whether she liked Canada's system or not. Her answer – "I hated it! You don't want it here". In the small province where she lived there was a 200-person waiting list to hook up with a doctor. It seems there is a shortage going on up there. She stated that all the doctors are coming to America to work. Therefore any problems she had would mean going to what is called "Outpatients" which is basically an urgent care center where the patients wait on average six to eight hours to be seen. If you are lucky enough to have a primary care physician then it still may take weeks or months to get in. A new rule put in place by the physicians is that the patient may speak of one problem only. If they bring anything else up they are told to reschedule another visit, which may take months to get in again. Want an MRI in Canada? My patient stated it takes about a year. In contrast, I got an MRI on my patient right

before I saw this Canadian one. It was scheduled for 48 hours later and it wasn't an emergency. Take that Canada. We may not be perfect here but we are better" (Farrago 2004c).

686. "In any event, here is my recommendation to the doctors of PA.—GET THE F&CK OUT!!! Sure you can say that you are there to help and what about the patients, etc. I am sorry but only when the legislators are bothered enough by the patients (which make up most of their voters) will they ever fix it. I also put a lot of the blame on the patients. They can protest just as well as the docs. I bet when all they have left to go see for their healthcare are Shamans and homeopaths, then we'll see things get better real quick" (Farrago 2004e).
687. Farrago's response was prompted by a letter from a surgeon which began "our legislature in Kentucky just passed a bill disallowing Medicare payments to providers (read doctors) for services performed at Specialty Care Hospitals in which they have an ownership interest" (Farrago 2004d).
688. In this example, Farrago is complaining about the Institute of Medicine report on mold allergies. He views this as a "bogus disorder"—the Institute of Medicine needs to get some balls and stop pandering to the psychosomatics" (Farrago 2004b).
689. Farrago lauds Dr. James Shoemaker in *Medical Economics* for saying "the medical profession is the only occupation I know of that is so heavily regulated that it is truly socialized." He also applauds Dr. Edwin Masters in *AMNews* for berating new immigrants for not speaking English—"now language skills are a medical expense and the abdication of individual responsibility marches on" (Farrago 2004a).
690. "Zombie masters" is from (Evans et al. 1993).
691. Robert Evans argues this point more strongly using the language of "nature" and "instinct:" "In Canada, however, the natural focus for collective activity has always been government. As residents of a small country heavily dependent on world markets, flanked on the north by a large and hostile wilderness and on the south by a large—and, well, large—neighbor, Canadians have instinctively turned to the state as the instrument of collective purposes. A multiplicity of competing organizations is a luxury we cannot afford" (Evans 1988: 169). Population of these small and large countries are as follows: The population of Canada, as of April 2004 according to Statistic Canada, was 31,825,416, accessed September 14, 2004: <http://www.statcan.ca/start.html>  
The population of the United States, as of September 14, 2004, was 294,273,199: <http://factfinder.census.gov/home/saff/main.html?lang=en>
692. Robert Evans asks: "...does the virtual elimination of the economic relationship between provider and patient violate some fundamental economic right of either provider or patient, or both? The United States Constitution, for example, is interpreted by the courts as entrenching certain fundamental *economic* rights. The rights to "life, liberty, and the pursuit of happiness" seem for Americans to refer, self-evidently, to the pursuit of money. On the other hand, as Canadians are fond of pointing out, the corresponding fundamental constitutional principle in Canada is the preservation of "peace, order, and good government." The new



Charter rights refer to “the security of the person,” which the courts have so far interpreted as meaning physical security rather than constitutionally protected rights to engage in economic activities. It would be premature to suggest that the jurisprudence has even begun to settle down in this area. We are probably in for years, if not decades, of extensive public and private support of the legal profession, some of whose members refer to the new legislation as their pension plan” (Evans 1988: 175). “Peace, order, and good government” comes from the first line of Section 91 of *The Constitution Act, 1867*. According to the Canadian Heritage website, this phrase “has become meaningful to Canadians and defines Canadian values in a way that is comparable to ‘liberté, égalité, fraternité’ in France or ‘life, liberty and the pursuit of happiness’ in the United States.”

Website accessed September 14, 2004:

[http://www.pch.gc.ca/special/gouv-gov/section1/infobox1\\_e.cfm](http://www.pch.gc.ca/special/gouv-gov/section1/infobox1_e.cfm)

693. Within this single-payer publicly financed mechanism, doctors who practice in the community and hospital-based physicians are not employees of the state. There are actually significant variations in the regulation of privately-financed hospital and physician services among the provinces. Physicians may practice outside the provincial plans in every province. Every province gives physician a choice of being outside the plan (paid directly by their patients) or within the plan (paid directly by the province). The consequences of opting out of the provincial plan differ from province to province but generally once physicians opt out, they give up their right to bill the plan directly for services provided to their patients (Sullivan and Baranek 2002: 41-43).
694. “In Canada, more than perhaps any other nation in the late twentieth century, the health care system functioned according to the logic of accommodation between the medical profession and the state. It was, in economic terms, the logic of an agency relationship in a bilateral monopoly” (Tuohy 1999: 119).
695. In the province of Ontario, for example, in order to receive reimbursement from the Ontario Health Insurance Plan (OHIP), physicians must pay membership fees to the Ontario Medical Association (McCrea-Logie 2001: 103).
696. All the dollar amounts within this footnote are in Canadian dollars. As with self-reported physicians’ income data reported by the United States Census, self-reported physicians’ income from Census 2001 (Statistics Canada) tends to be lower than other data sources. Self-reported average income for full-time physicians in Canada in 2000 ranged from just below \$120,000 in Alberta and British Columbia to more than \$140,000 in New Brunswick (Canadian Institute for Health Information 2004a: 10). The National Physicians Database contains provincial/territorial government payment and service count information based on physicians’ billing claims. It included gross payment information primarily based on fee-for-service data. For physicians working full-time (those who averaged more than \$60,000 per year), the average payment per physician varied from approximately \$180,000 in Québec to around \$240,000 in Ontario and Alberta (Canadian Institute for Health Information 2004a: 9). Overhead expenses, which can include office equipment and supplies, staff salaries, rent, and fees to maintain licensure and membership in professional organizations varies from 27% for medical specialists, 33% for surgical specialists, to 35% for family/general practitioners (Canadian Institute for Health Information 2004a: 11). According to the Canadian Medical Association’s Physician Resource

Questionnaire Survey, there has been a declining proportion of physicians who receive over 90% of their income from fee-for service remuneration from 62.3% in 1999 to 52.5% in 2003 (Canadian Institute for Health Information 2004a: 13).

697. Greater economic autonomy lies within the relative freedom of Canadian physicians to “have more control over their method of payment, more freedom to negotiate collectively fees with the government, more freedom to accept gifts from industry and make self-referrals, and more fraud and abuse protections under the billing system” (McCrea-Logie 2001: 1-2).
698. The Canada Health Act “reaffirmed the program criteria for public health insurance and specified that the federal government could withhold some of its contribution from any province that breached them. But it was only specific about the penalties for user fees and extra-billing: the act stipulated that federal transfers to the provinces would be reduced, dollar for dollar, by the amount collected through direct charges to patients” (Rachlis and Kushner 1994: 35). Extra-billing occurs when physicians charge a patient more than the amount that has been deemed appropriate for the service under the provincial plan. All provinces, except for New Brunswick and Prince Edward Island, prohibit extra-billing by opted-in physicians. Some provinces that prohibit extra-billing (Alberta, British Columbia, and Newfoundland) allow exceptions—for example, an opted-in physician may charge extra for equipment or materials that are necessary to provide services for a publicly insured service in some cases. For physicians who have opted out of the provincial plans in Manitoba, Nova Scotia, and Ontario, there are specific regulations prohibiting physicians from charging more privately than what the public plan would pay. In the other seven provinces, physicians who are opted-out may charge what they want, except for certain exceptions. For example, in British Columbia, opted-out physicians cannot extra-bill for services provided in public hospitals or community care facilities. In six of the seven provinces that allow opted-out physicians to extra-bill, the provinces discourage extra-billing through the elimination of cross-subsidization by public funds—patients must pay the full bill without being reimbursed by provincial plans (Sullivan and Baranek 2002: 43-45).
699. Monique Bégin, who was the Minister of Health when the Canada Health Act was passed, gives this historical account: “Then, around 1987, following the bitter Ontario doctors’ strike, Canadians were assured that extra-charges would not be tolerated. After three years and some \$245 million of cash penalties imposed to seven provinces (reimbursed after they stopped violating the Canada Health Act), Medicare was back on track. Canada’s attachment to their beloved No. 1 health care system had been reinforced in the process” (Begin 1999: 3).
700. A survey of 1,028 Ontario physicians (69% response rate) revealed 42% of the respondents participated in the 1986 strike. The following were risk factors identified with participation in the strike: income greater than \$135,000; being a surgeon or gynecologist; having previously “opted out” of the Ontario Health Insurance Plan; being professionally dissatisfied; being politically conservative; favoring political activism by physicians; holding a positive view of the social consequences of extra-billing; and perceiving family, associates, patients, and the public in favor of the strike (Kravitz et al. 1989: 1227). Richard Kravitz and colleagues categorizes physicians at “high risk” for participating in this strike

into four groups: economically rational, ideologically committed, professionally disaffected, and socially malleable (1989: 1230).

701. In a national survey of Canadian physicians conducted between November 1986 and May 1987 with a 67% response rate (2,397 completions), 52% of the physicians favored reestablishing extra billing (Stevenson, Williams, and Vayda 1988: 81). The authors found "the opinions of most doctors are consistent with an underlying ideology of medical dominance and professional autonomy. In these terms, a majority of physicians defend professional autonomy in the determination of incomes, support various privatization policies, and agree that Medicare has resulted in a direct loss of physician control over medical decisions" (Stevenson, Williams, and Vayda 1988: 88).
702. Advocacy groups that have joined together to file this action include the Council of Canadians and the Canadian Health Coalition. The Council of Canadians was founded in 1985 as a non-partisan, citizens' watchdog organization to lobby Members of Parliament, conduct research, and run national campaigns "aimed at putting some of the country's most important issues into the spotlight: safeguarding our social programs, promoting economic justice, renewing our democracy, asserting Canadian sovereignty, advancing alternatives to corporate-style free trade, and preserving our environment." Their website was accessed September 19, 2004: <http://www.canadians.org/>. The Canadian Health Coalition was founded in 1979 and is a strong voice advocating publicly funded and delivered health care in Canada. <http://www.healthcoalition.ca/>
703. Unions that are affiliated with the Canada Health Act legal challenge include the Canadian Union of Public Employees, Communications Energy and PaperWorkers Union of Canada, and the Canadian Federation of Nurses Unions. The latter represented every provincially-based nurses' union, except for Québec. Information on this lawsuit obtained from the Canadian Health Coalition website, accessed on September 19, 2004: <http://www.healthcoalition.ca/cha-lawsuit.html>
704. Auditors General of Canada have repeatedly documented the failure of successive Ministers of Health to live up to those obligations of monitoring, reporting and enforcement under the Act. Many of these shortcomings have continued for years. As a result of the Minister's failure to report on compliance by the provinces with the criteria and conditions of the Act, the Auditor General concluded in her 2002 report that 'Members of Parliament cannot determine from the *Canada Health Act Annual Report* whether the spending of billions of dollars transferred to the provinces and territories results in health care delivery that meets the intent of the Act.' Moreover, Ministers of Health have chosen to systematically ignore violations of the Act....Widespread misconceptions about the performance of the health care system abound precisely because the federal government has failed to properly monitor and report on compliance, as well as enforce the Act. This has created a sense of crisis where none is justified and undermines public confidence in and support for Canada's Medicare system. At the same time, problems that may undermine the effectiveness of Canadian public health care insurance plans remain hidden and are allowed to persist. Particularly troubling is the Minister's failure to stem the proliferation of privatization across the system which can undermine the objectives and purposes of the Act" (Canadian Health Coalition).

705. "Privatization of public services occurs when governments—stop paying for or providing a service; still pay for a service, but turn it over to the private for-profit sector; still pay for a service, but require the patient to assume part or all of the cost; still provide and pay for a service, but use private sector methods in managing and delivering it; send care home where families, friends and volunteers, most of whom are women, are expected to provide unpaid care" (Armstrong, Armstrong, and Fuller 2000: 4).
706. Linda McQuaig is actually critical of this characterization of Paul Martin as "a humane and reluctant budget cutter." The quotations characterizing Martin in this section are originally attributed by McQuaig to (Greenspon and Wilson-Smith 1996).
707. Some argue that Canada *must* increase private funding, whatever its distributional effects, because needs are expanding and more public money, for various reasons, simply cannot be provided. These claims are false. They portray a political choice as an economic necessity....Management of health expenditures remains a demanding priority for all modern governments, but the public system is not outrunning Canada's fiscal capacity. The real "cost explosion" is in prescription drugs, roughly half financed from private sources" (Evans 2002b: vi). The Canadian Center for Policy Alternatives first began to do alternative federal budgets (AFB) since "the historic 1995 Paul Martin budget, which declared war on the deficit by bringing down the deepest non-military program cuts in Canadian history...From the beginning our goal has been to show that governments do have choices, that the claim that 'there is no alternative' is a cover for a deliberate 'small government' policy agenda that has come to be known worldwide as the Washington consensus, or neo-liberal consensus. The AFB is a 'what if' exercise: what a government could do if it were truly committed to a progressive social and economic agenda" (Canadian Center for Policy Alternatives 2004: 1).
708. It needs to be pointed out that this specific share is more difficult to calculate and more contested than it might first appear. A review of different perspectives that estimate the provincial health care costs paid via Canada Health and Social Transfer (CHST) Cash in 2001-2002 ranged from 11.6% to 13.4% to 18.2% with dollar figures ranging from \$7.9 billion to \$12.4 billion. Reviewers caution that "this range of different, and each partially valid, perspectives should make clear there is *no single number and no right number that objectively represents the federal CHST cash contribution for health* (Lazar et al. 2002: 20).
709. Robert Evans argues that wary federal-provincial relationships are not new: "The longest and most carefully defended border in the world is between the government of Canada and the provinces of each of the provinces. Canadians have a fascination with federal-provincial relations that most other nations reserve for religion or sex" (1988: 172).
710. Alberta's "Framework for Reform" argues that "without changes, spending on health care is not sustainable" (Mazankowski 2001: 27). This report uses market language by calling for a re-configuration of the health system to "encourage more choice, more competition and more accountability" (Mazankowski 2001: 7) to put "customers" first (Mazankowski 2001: 6). Five of the twelve Premier's

Advisory Council on Health for Alberta are physicians: Larry Bryan, John Evans, M. David Low, Ken Nickerson, and Eldon Smith (Mazankowski 2001). John Evans is a board member of MDS (Puscas 2002: 3), GLYCODesign (a pharmaceutical company), and DPS Pharmaceuticals (Barlow 2002: 130).

711. The First Ministers meeting between the provincial premiers and Prime Minister Paul Martin was described as “a Gong Show” (Calgary Herald 2004), and “the raw material for reality TV or even a pretty good sitcom” (Travers 2004). Alberta Premier Ralph Klein left the three-day meeting after the first day and his comment to mark the conclusion of this meeting was “I really don’t want anything. I want to be left alone so we can get on with reforming our health care system to make it sustainable” (Panetta and Bryden 2004). “Under this week’s agreement, Ottawa will spend an additional \$18-billion on health care over the next 6 years. To understand where the numbers come from, it’s easiest to think of it as a grab-bag of one-time goodies for the provinces combines with a boost in the annual transfers by Ottawa. Beginning in 2006, the base level of funding to the provinces will rise 6 per cent a year for the next decade. The balance of the rest of new \$18-billion in spending comes through one-time and permanent increases to funding for waiting-time reductions, new medical equipment, home care and catastrophic drug coverage” (Laghi and Tuck 2004).
712. According to Rick Scott, former CEO of HCA, who “vowed to destroy every public hospital in North America,” “Healthcare is no different from the airline or ball bearing industry” (Puscas 2002: 2).
713. The figure of 10%-15% return on investment is from (Devereaux, Shunemann et al. 2002: 1404).
714. “Of the 14 studies that evaluated adult populations and adjusted for potential confounders, 6 had a statistically significant lower relative risk of death in the private not-for-profit hospitals, and one had a statistically significant lower relative risk of death in the private for-profit hospitals. Meta-analysis of these 14 studies demonstrated the private for-profit hospitals were associated with an increased risk of death (relative risk [RR] 1.020, 95% CI 1.003-1.038: p = 0.02). One study of perinatal mortality that evaluated 1,642,002 patients in 243 hospitals and adjusted for potential confounders also demonstrated an increased risk of death in private for-profit hospitals (RR 1.095, 95% CI 1.050-1.141: p < 0.0001) (Devereaux, Shunemann et al. 2002: 1402).
715. This meta-analysis involved eight observational studies that included more than 500,000 patient-years of data, reporting from January 1, 1973 through December 31, 1997, with a median of 1,342 facilities per study. “Six of the 8 studies showed a statistically significant increase in adjusted mortality in for-profit facilities, 1 showed a nonsignificant trend toward increased mortality in for-profit facilities, and 1 showed a non-significant trend toward decreased mortality in for-profit facilities. The pooled estimate, using a random-effects model, demonstrated that private for-profit dialysis centers were associated with an increased risk of death (relative risk, 1.08; 95% confidence interval, 1.04-1.13: p < .001)” (Devereaux, Choi et al. 2002: 2449). “Approximately 20% to 25% of US in-center hemodialysis patients die each year, and our meta-analysis found a pooled RR of death of 8%, suggesting that private for-profit dialysis facilities may be responsible for a substantial number of excess death” (Devereaux, Choi et al. 2002: 2452).

716. “Eight observational studies, involving more than 350,000 patients altogether and a median of 324 hospitals each, fulfilled our eligibility criteria. In 5 of 6 studies showing higher payments for care at private for-profit hospitals, the difference was statistically significant: in 1 of 2 studies showing higher payments for care at private not-for-profit hospitals, the difference was statistically significant. The pooled estimate demonstrated that private for-profit hospitals were associated with higher payments for care (relative payments for care 1.19, 95% confidence interval 1.07-1.33,  $p = 0.001$ )” (Devereaux et al. 2004: 1817). In a comment on the outlier in this study: “the only significant exception was a small study comparing private for-profit hospitals with nominally not-for-profit hospitals run by a private, for-profit firm—in other words, both groups of hospitals in this study were under for-profit management” (Woolhandler and Himmelstein 2004: 1814).
717. “For the United States and Canada, we calculated the administrative costs of health insurers, employers’ health benefit programs, hospitals, practitioners’ offices, nursing homes, and home care agencies in 1999. We analyzed published data, surveys of physicians, employment data, and detailed cost reports filed by hospitals, nursing homes, and home care agencies. In calculating the administrative share of health care spending, we excluded retail pharmacy sales and a few other categories for which data on administrative costs were unavailable...Costs are reported in U.S. dollars. In 1999, health administration costs totaled at least 294.3 billion dollars in the United States, or 1,059 dollars per capita, as compared with 307 dollars per capita in Canada...Canada’s national health insurance program had overhead of 1.3 percent: the overhead among Canada’s private insurers was higher than in the United States (13.2 percent vs. 11.7 percent) (Woolhandler, Campbell, and Himmelstein 2003: 768).
718. “Proposals to shift toward more use of quasi markets, through the extension of private funding mechanisms, are distributionally driven. They reflect the fact that, compared with public funding systems, privately regulated quasi markets to date have been: a) less successful in controlling prices and limiting the supply of services (more jobs and higher incomes for suppliers); b) supported through more regressive funding sources (the healthy and wealthy pay less, whereas the ill and wealthy get preferential access); c) off-budget for governments (cost shifting in the economy looks like cost saving in the public sector)” (Evans 1998: 66-67).
719. Robert Evans (2002b: 42) concludes his report to the Commission on the Future of Health Care in Canada as follows: “Those who claim that the public insurance programs are taking up an increasing and unsustainable share of national and/or public revenues have simply failed to check the fiscal facts. Nor is there any basis for the claim that Canada has reached some absolute limit, for political or economic reasons, in the amount of public money available for health care. The real motive underlying proposals for more private financing is very simple. ‘The more private funding we have, the more those with high incomes can assure themselves of first class care without having to pay taxes to help support a similar standard of care for everyone else’ (Roos and Frohlich 2002).
720. “Indeed, advocates for changing the financial mix in the direction of less taxation and more private financing do *not* highlight the regressive transfer of

income from the unhealthy and wealthy to the healthy and (especially) wealthy that are their primary and inevitable effect. Instead, they argue that linking financial liability to the use of care will bring other benefits, leading to a more efficient and more effective health-care system" (Evans 2002b: 38).

721. "...physicians' representatives have for many years pressed for the right to extra-bill patients, over and above provincial reimbursement schedules, on the explicit ground that this would yield them higher fees and incomes....It seems likely that any form of user fees that was to be collected by physicians would (re)open the door to such extra-billing—once patients are being charged for care, it may be difficult for them to keep track of how much they are being charged, and whether the practitioner is adding in an extra fee of his/her own" (Evans 2002b: 32).
722. The editorial board of the *Calgary Herald* has suggested Calgarians should let their relatives, especially their relatives who are physicians, know about the "Alberta advantage for doctors." "If you add up income taxes, health taxes, sales taxes and an average property tax burden, a single doctor who earns \$160,000 pays \$13,543 less tax in Alberta (\$55,433 total taxes) than in Ontario (\$68,976 total taxes). Alberta's tax advantage over Québec (\$72,769 total taxes) is even bigger: \$17,336. The difference in income tax and health tax alone between Alberta and Ontario is worth \$9,710 annually, according to the *Calgary Herald*. The editors point out that this sum will cover 12 monthly BMW payments of \$809.16" (Kermode-Scott 2004).
723. Physicians who provide fee-for-service medical services in Québec are unionized, with general practitioners and specialists belonging to separate unions. The British Columbia Medical Association has discussed becoming a union since the 1970's although "in most respects the BCMA was already a union" (Farough 1996: 201-202). The BCMA held a vote in 1993 and 64% of the membership rejected the unionization strategy (Farough 1996: 205). The health minister, Elizabeth Cull, responding to a BCMA press announcement as they pondering forming an union said that she would welcome the concept of doctors in a union because then doctors would have to "stick to issues like fees and benefits and working conditions. Referring to the bone of contention in the current dispute, Cull said she could only assume that the doctors realized that unions do not negotiate government budgets...Ken Georgetti of the B.C. Federation of Labour said that doctors would need a lesson in solidarity if they wished to form a union. Commenting on the BCMA's negative reaction to the latest agreement negotiated with the health care unions, Georgetti warned that the rest of the labour movement would not feel 'sympathetic to the needs of doctors when they don't reciprocate.' Carmela Allevato of the Hospital Employees Union commented: 'It's interesting that the group which is at the top of the hierarchy in an industry that's extremely hierarchal is looking to trade unionism to advance its collective rights'" (Farough 1996: 202).
724. In August of 1981 the British Columbia Medical Association filed a legal challenge asking the court to declare that Bill 16 "was beyond the power of the legislature to enact. If that part of the suit succeeded, the BCMA planned to ask the court to pay doctors an estimated \$50 million for losses incurred while the legislation was active" (Farough 1996: 158). The BCMA then changed its strategy to argue that the doctors had been deprived of a property right and so were

entitled to compensation. Justice Wallace ruled in June 1983 that there had not been “a taking or acquisition by the crown of any property or right of the doctors and they were not entitled to compensation for the loss of the balance-billing privilege.” An appeal was launched by the BCMA but it was lost in November of 1984, seven months after the Canada Health Act was proclaimed law (Farough 1996: 162).

725. Harold Luft’s article entitled “Why Are Physicians So Upset About Managed Care?” quotes H. L. Menken: “When they say ‘It’s not about money’ it’s about money” (Luft 1999: 960).
726. “After negotiations failed, the 23 northern doctors from 5 communities resigned their hospital privileges on Jan. 31. They were joined in March by 39 members of the new Rural Doctors Group, which represents physicians in the eastern part of the province and the Gulf Islands. ‘There should be value for our services and we should get relief,’ says Brodie, who has been in Burns Lake for 9 years. The doctors want an on-call stipend of \$500 for a week-night and \$1,000 for weekend days so they can afford to take the next day off from their clinics; they also think the moves would attract other doctors to the area. Brodie says it’s not a question of more money. ‘Right now our lifestyle is the pits. I’ve worked 80-hour weeks on average for years. We just couldn’t do it any more’” (Sibbald 1998: 1507). Robert Evans and colleagues, in contrast, argues: “‘More money’ can mean either more services, or just higher incomes. The Reduced Activity Days campaign waged by B.C. physicians over the last few years makes the point clearly. They have been quite deliberately and explicitly withholding services—trying to create a shortage—in order to protect their fee levels. They argue that the B.C. government has not been providing sufficient funding to pay for an increased number of medical services, but in fact the conflict is actually over the rate at which those increased services are to reimbursed—the fee level” (2000: 39). A relevant point here is that “physician fees in British Columbia have been the highest, or among the highest, in the country for decades” (Barer, Evans, and McGrail 2004: 1647).
727. Dr. Allidina, an Ottawa psychiatrist, said, “It was a contract and the government was breaking the contract. All I was saying was, ‘Pay up or get off the pot, or tell the patients, the public, how much service you’re willing to provide.’ He said the public must make their feelings about health care clear to politicians. If they want an extensive buffet of services, they must lean on legislators to fund them; if they don’t want tax increases, then press to have some items dropped from the public insurance plan. ‘The patient, instead of playing the role of victim, has to take an assertive position one way or the other. I don’t see the patient as a pawn—patients have a choice and they have to make a decision’” (Baer 1997: 1269).
728. At the 2004 first ministers’ meeting, for example, Ralph Klein made a “stunningly insensitive reference to the role of ‘herbs and berries’ in aboriginal medicine” (Travers 2004). Klein left this meeting after the first day to return to Alberta to speak at an oil industry conference as “there’s no bloody votes in Ottawa” (Cordon 2004). It was also noted by the press that Klein left the premiers dinner with the prime minister early to go gambling at the Casino du Lac-Leamy: “It’s a silly little story that began with a seed planted by officials from the Prime Minister’s Office who told reporters that Klein had left the dinner early. Without



saying so, they make it sound like an ill-humoured Klein had stomped out of the meeting while his colleagues were on the cusp of finding a solution to the country's health care ills. A reporter spotted Klein at the Westin Hotel withdrawing \$300 from a bank machine and heading for the door. Enterprising reporters put two and two together and realized there was nowhere to go in Ottawa on a Sunday night with \$300 in your pocket. So, they headed for the casino across the Ottawa River in Québec, just to see if their hunch was right. It was" (Thomson 2004).

729. The Secretary-General of the Canadian Medical Association, J. D. Wallace, suggested that a clear articulation of the goals and objectives of the CMA as the recognized "voice of Canadian medicine" had instrumental as well as inherent value. "Never before has the CMA publicly made it so clear that it is not primarily a self-centered, self-interest group interested only in getting all it can for the doctors of Canada" (Wallace 1974: 348). Dismay with public perceptions about physicians' self-interest is a common complaint by physicians: "It is fair to conclude that the vast majority of the public cares little about how physicians are compensated as long as they receive the service and do not pay for it directly. Even though the public would like to be surrounded by happy physicians, this is frequently overlooked if it comes to the choice about the method of payment. Behind this overall stance is the reality that many members of the public are influenced by the belief that unnecessary services are being perpetrated upon them by doctors who have a vested interest in the fee-for-service model" (Ontario Medical Association 1987: 7-8).
730. Given a long-standing concern about the public's perception of doctors' pursuing their own self-interest, Ralph Klein's comments were not well received by those in leadership positions within the medical community. The president of the Canadian Medical Association, Dr. Henry Haddad, called Klein's remarks "unfortunate" and not helping "the emotional health-care debate." Dr. Robert Hollinshead, the president of the Alberta Medical Association, described Klein's comments on doctors' profit motives as "a drive-by smear against Alberta doctors" (Olsen 2002).
731. This point is made by Dr. Michael Gordon, vice-president of medical services at Toronto's Baycrest Center for Geriatric Care, who is "an outspoken critic of doctors' strikes." Gordon said, "If job actions are repeatedly undertaken for what seems to be self-centered gains, they may eventually result in compromised professional credibility" (Baer 1997: 1271). The following excerpt from a letter to the *Canadian Medical Association Journal* gives strong reasons why the Ontario physicians' strike was such a public relations disaster: "Arguments against the Ontario doctors' strike, as presented mostly in letters to the editors of Ontario newspapers, included the violation of the Hippocratic oath, the fact that Medicare has provided doctors with a guaranteed income well above that of the average member of the middle class, the fact that the education of doctors is highly subsidized by the public, as are the hospitals the doctors wanted to close and as is much of the equipment they use in those hospitals, the fact that when the government offered to guarantee professional freedom the doctors, who claimed that this freedom was the real issue, still refused to end the strike, the refusal of doctors to extend this highly prized freedom to such related professionals as midwives, chiropractors, and naturopaths, the fact that it was not the government that was hurt by the strike but real people with real

problems, and the fact that the people of Ontario were overwhelmingly against the strike. It surprises me that the Ontario and Canadian medical associations were not more articulate and effective in defending the doctors' actions. I have yet to see any answer to these arguments except "The strike wasn't about money" and "The next step will be to dictate where and how doctors can practice." No one ever bothers to explain exactly how the latter is going to happen just because extra-billing is banned, and I have yet to see any convincing evidence that Bill 94 does anything but ban extra-billing.....I would have more respect for the profession as a whole if its leaders would refrain from misleading, inflammatory rhetoric and instead answer the public's questions. I would have more faith in the self-policing nature of the profession if, in fact, there *were* a bit of policing of those doctors who chose to harm the public in order to protect their purses" (Sinclair 1986: 429).

732. Although the term "boutique medicine" is not used, one would be hard pressed to differentiate the following illustration from Ontario from those discussed in Chapter Eight: "In a North York medical practice, some patients reportedly pay a \$2,500 membership fee for 'personalized health planning' that includes shorter waits for MRI scans" (Grieshaber-Otto and Sinclair 2004: 130).
733. Montreal has been described as "a mecca" for patients seeking gender reassignment surgery. A plastic surgeon, Dr. Yvon Ménard, and his colleague, Dr. Pierre Brassard, provide "red-carpet treatment: limousine, private room, catered meals" and perform approximately 200 vaginoplasty and phalloplasty surgeries per year. They have a waiting list that is over one year long and 95% of their patients are Americans. Vaginoplasty at Ménard's private hospital costs between \$9,800 and \$11,000 (Canadian dollars) compared with \$14,000 to \$25,000 (US dollars) in the United States. Amidst the specific financial details (phalloplasty is \$28,000 Canadian), the author of this article points out for Ménard's patients "though, cost isn't the most important factor. 'We take care of them as if they were our children, our brother and our sisters,'" Ménard says. Debra, "another American transsexual who came to Montreal for surgery," was quoted as saying, "You can't buy this kind of compassion" (Pinker 1999b: 1368).
734. Different rules and interpretations that vary from province to province make the Canadian system, like the American system, often difficult to understand. An exception to the rules that is now being heralded as a model is the Shouldice Clinic in Toronto. This private hospital that specializes in simple hernia operations was "grandfathered in" under the 1973 Private Hospital Act when Ontario moved to public medicine. Senator Wilbert Keon, an Ottawa heart surgeon and senator appointed by Brian Mulroney, said in a 2002 interview that "it was time for Canadians to embrace private health care" and that the "Shouldice Clinic could be replicated to perform other specialty surgeries, such as orthopedics" (Barlow 2002: 137).
735. An example from another province could be the disingenuous template displayed by British Columbia surgeon, Brian Day, who raised "financing through 22 owner-investors (including 15 physicians)" to open the \$4 million Cambie Surgery Center (Jones 1997: 298). "The centre's goal is to develop and maintain a centre of excellence in surgery. It can provide plastic and cosmetic surgery, as well as dental, oral, orthopedic (including arthroscopic and sports injury), general, laparoscopic, gynecologic, ophthalmologic, urologic and

otolaryngologic procedures....Most of the medical staff hold faculty positions at the University of British Columbia,' the website says, 'and many are national and international leaders in their specialty" (Jones 1997: 298). Using the same logic as the specialty hospitals, Day said "the main reason for establishing Camie is to provide both the latest equipment and abundant operating room time" (Jones 1997: 300). "What I've done is say that if there are no operating rooms at UBC, I'll build my own" (Jones 1997: 300). Day is also the president of an association representing about 30 private clinics in British Columbia. Day argues, "If there were no waiting lists in the public sector, there would be no need for a private facility. But what has happened is Canadian politicians have promised a complete smorgasbord of health care and no limits on expenditures. In the 1990s that is a promise they cannot fulfill. We have to step in or see patients wait in line" (Jones 1997: 298). Despite international evidence that for-profit medicine does not shorten waiting lists (Sullivan and Baranek 2002: 61), Day promises something that his for-profit cannot deliver and suggests that the deficiencies of the public system, which he is actively eroding, further justify his for-profit medicine. Day says, "...by catering to foreign customers, private clinics benefit the Canadian economy and, in the long run, provide taxes and medical expertise to meet the health needs of Canadians. 'This is potentially the biggest industry in Canada,' says Day, 'yet our political leaders are afraid to go after this market because it will expose the deficiencies in our own system, namely surgical waiting lists. How can it be that foreigners come into Canada, have medical treatment by the best doctors in our city right away, and as a BC patient I would have to wait 6 months?'" (Jones 1997: 300). Called "Doctor Profit" on a magazine cover, Brian Day is also credited for being the inspiration for Specialist Referral Clinic. This involves a group of specialist doctors opening a facility where, for a fee of \$350 to \$500, patients can by-pass their family doctors to see a specialist without the usual wait to obtain such an appointment (Barlow 2002: 142-143).

736. The six million was for renovations. "Its soothing colour schemes, oak and brass trim, and carpeted floors complement 3 state-of-the-art operating rooms, 37 beds, 8 day-surgery beds and 6 postop recovery beds" (Cairney 1998: 551). Richard Plain, a University of Alberta health care economist and vice-president of the Consumers' Association of Canada, "says HRG is a recipient of corporate welfare paid for by a provincial government more concerned with bottom-line issues than providing an adequate public system... 'Jim Saunders had his infrastructure handed to him on a silver plate,' says Plain... '[Alberta taxpayers] sank tens of millions of dollars into that facility. Then the CRHA, acting as agent for the government, looks at the situation in Calgary and says, 'Grace Hospital? The best we can do is close you down now.' It was one of the hospitals tanked for its inability to fit in with cost-effective care"(Cairney 1998: 552).
737. The 1997 business plan for the Health Resources Group (HRG) said, "whenever possible, these services will be offered in a non-union environment" (Fuller 1998: 184). "The company's plan included the establishment of a for-profit chain of hospitals, beginning in Calgary and expanding rapidly to locations in Edmonton, Toronto, and Vancouver. HRG planned to offer, among other things, orthopedic, general, and plastic surgery: inpatient and outpatient medical and rehabilitation services; and services to support clinical drug trials" (Fuller 1998: 184).
738. Powerful backers for the Health Resources Group included executives from two health multinationals: Sun Healthcare (parent of Columbia Health Care) and MDS (Fuller 1998: 184). This "Columbia Health Care, Inc (not to be confused

with U.S. based Columbia/HCA), for example, is considered a stellar success story by many corporate and government leaders who support privatization. Founded in 1978 in Kelowna, B.C., by a psychiatrist Dr. Charles Gregory, Columbia provided rehab services for patients in the region suffering from chronic back pain" (Fuller 1998: 101). Canada's largest health corporation, MDS Inc. ended up with 42% of Columbia's shares in 1990, and then Columbia was sold to New Mexico-based Sun Healthcare Ltd in 1995 (Fuller 1998: 102-104). According to Warren McInteer, who was in charge of Sun Health's mergers and acquisitions strategy, this company was "interested in the transition in the Canadian marketplace from the public sector to the private sector" (Fuller 1998: 107). MDS Inc. was founded in 1969, as Medical Data Sciences, Ltd., by five former employees of IBM's medical services division (Fuller 1998: 246). "MDS and its many partners, both in the corporate and nonprofit sectors, have focused their combined energies on 'growing' the private health market in Canada. Physicians played a key role in the company's early years, providing its laboratories, in particular, with medical expertise in diagnostic procedures. This association increased MDS's credibility and, just as importantly, the number of patients referred to its labs for blood testing. Today, however, doctors have less significance in the overall strategies than other, more important links that have developed in the 1990's. MDS's partnering has increasingly occurred with Canadian, U.S., Asian and European corporations such as Dupont Merck, the Pfizer Corporation, Bristol Meyer-Squibb, BCE, Inc., Manulife, Dynacare, Columbia/HCA, Liberty, the Allegiance Corporation, HealthStreams, the Royal Bank of Canada, and British Aerospace" (Fuller 1998: 247-248). MDS owns 37 percent of Health Resources Group (Puscas 2002: 3).

739. "The head of HRG's board was Peter Burgener, an architect, former chair of the Calgary District Hospital Group, and husband of a member of Ralph Klein's government. The president of HRG was Jim Saunders, former chief operating officer with the Calgary Regional Health Authority, the body that oversaw the city's hospital services. During his term at CRHA, Saunders supported the participation of for-profit companies in the delivery of a range of health and diagnostic services including nursing and home care, cataract surgery, rehabilitation, and palliative care" (Fuller 1998: 184-185).
740. Dr. Stephen Miller, a cofounder of HRG and its chief medical officer, was chief of orthopedic surgery at the Foothills Hospital and an associate clinical professor at the University of Calgary. "Dr. William Cochrane, another director, was a former dean of medicine, former president of the University of Calgary, and former deputy minister of health services for Alberta. More importantly, Cochrane headed up a health venture capital fund owned by multinational health conglomerate MDS, Inc. MDS managed the Canadian Medical Discoveries Fund, another venture capital project based in Ottawa, which had contributed \$2 million in start-up capital to the for-profit hospital" (Fuller 1998: 185). As mentioned in an earlier footnote, Dr. John Evans, is a board member of MDS (MDS owns 37 percent of the Health Resources Group) and a member of the Alberta Premier's Advisory Council on Health recommending health care reform in the province (Puscas 2002: 3).
741. "Directly and through venture capital funds it manages, MDS has invested \$3 million in the start up costs of HRG's hospital, and three MDS representatives sit on the HRG board of directors. And, to close the circle, MDS, its partners and

subsidiaries together are the province's largest donor to the Alberta Tories" (Canadian Union of Public Employees 2000: 8).

742. "Miller, like other surgeons practicing at HRG, promised he would only work part time in publicly supported hospitals—although none of them would be in Calgary's inner city because all had been closed by the province" (Fuller 1998: 187-188). This does not address the basic problem identified by Richard Plain: "The public system is suffering because doctors are allowed to straddle the 2 systems, he suggests, and waiting lists will grow because doctors are spending more time in the private system for financial reasons. 'You get doctors with the greater skills going where the money is, so you get an erosion of the public system. Instead of the best doctors doing the most difficult work, they are doing the most lucrative work'" (Cairney 1998: 552).
743. There was a provincial and professional jostling that underlies what this facility is called. When HRG opened in 1997 offering dental and cosmetic surgery for day-stay patients, there was no difficulty getting accredited by the College of Physicians and Surgeons. Once HRG applied to expand its services to include procedures that required an overnight stay, then the College of Physicians and Surgeons said that changed the status of the facility to a hospital, which required provincial accreditation. The provincial government then argued that the legal definition of a hospital in Alberta was a facility that was publicly funded and therefore the College of Physicians and Surgeons did have the authority to regulate HRG. Then HRG said it would like to be classified as a "surgical corporation" and the Klein government responded with the label of "clinic" rather than hospital—putting it back to the College of Physicians and Surgeons. The United Nurses of Alberta did a comparison of the services offered by Grace Hospital as hospital and those proposed by HRG and concluded that calling one a hospital and one a clinic "is obviously an attempt to circumvent the requirements of the Canada Health Act" (Fuller 1998: 187). HRG is prominently discussed in accounts of the three tries that it took Ralph Klein to get legislation passed that would allow private clinics to perform surgery that requires an overnight stay. HRG's "lobbying tirelessly" for this legislation included "a battle for the hearts and minds of Albertans, going so far as to sue the province's New Democratic Party and the party leader for defamation" (Cairney 2000b).
744. The full quotation by Dr. Stephen Miller once extended-stay procedures were authorized is as follows: "This is a very positive opportunity for physicians to be able to give more and better care to their patients. We're all frustrated by the limits placed upon us in a health care system that has limited resources. The limited resources are pulling the standards of care down to a level that's not acceptable. We need more resources to allow us to give more expedited care. This is a creative way of doing it" (Kermode-Scott 2002).
745. Under a sub-title "Extra-billing the patients under a new name," it is argued: "But revenues can be enhanced both by increasing price, and by increasing volume. If prices for insured professional services are constrained—as by a provincial reimbursing agency—the natural response is the create an expanded product line...Canadian physicians have always chafed at the constraints imposed by globally negotiated fee schedules and have argued for the opportunity to extra-bill their patients for their professional services. The private clinic provides motivation and opportunity to promote additional, uninsured

services, which carry substantial profit margins" (Evans et al. 2000: 23). Increasing volume is a strategy used by some physicians within the provincial reimbursement system. One study found 219 general practitioners and family physicians (GP/FPs) (2.5% of GP/Fps in Ontario) billed the Ontario Health Insurance Plan over \$400,000 in 1994-1995. High-billing physicians tended to be male, established physicians, and foreign graduates and they were more likely to perform diagnostic and therapeutic procedures and derive a higher proportion of their billing from them. "Many of these procedures are self-referred services: the GP/FP not only orders them but also performs and bills for them" (Chan, Anderson, and Theriault 1998: 745). Gaming the system and fraud are also tactics for revenue generation sometimes used in the Canadian context, as elsewhere. For example, twelve physicians associated with a walk-in clinic in Mississauga, Ontario were charged with defrauding the Ontario Health Insurance Plan of \$2 million between January 1 and December 31, 1997. Detective Staff Sergeant Keith Messham of the Ontario Provincial Police's health fraud investigation unit said, "We're alleging they billed services that were not rendered and that they billed for services that were not medically necessary. We're also alleging they billed for medically unnecessary referrals" (Mitchell 2000).

746. Ralph Klein's electoral fate will be fascinating given that the Conservative party co-chair, British Columbia MP John Reynolds, blamed Klein for "damaging the party's electoral fortunes by dropping a health care 'grenade'" during the 2004 federal election campaign. "Klein's statement during the campaign that he was considering reforms that could violate the Canada Health Act hurt the Conservatives, especially in British Columbia and Ontario." After the election, Klein revealed that "on the table will be proposals for both higher health-care premiums and an income based-deductible on the use of health-care services....Klein told reporters Alberta would consider opting out of the Canada Health Act if Albertans supported the move. 'Considering now that the federal government pays so little toward the maintenance of health care across the country, we will have to assess whether the loss is greater than the gain we might make. There's nothing that says you have to stay in the Canada Health Act. The only thing is that if you opt out, you lose payment for a particular procedure that is seen to be in violation'" (Maccharles 2004).
747. Tom Saunders, CEO of HRG, explains, "If you specialize, you no longer have all the costs of an acute care hospital—there's no ER that is full one day and empty the next, no ICU—an acute care hospital has to service all needs. We don't have all those costs and therefore we don't have the same huge infrastructure that requires more people" (Cairney 2000b: 409). In this article in the *Canadian Medical Association Journal* the point is made both that "Saunders is up front about HRG's profit-driven nature" and "in the larger scheme of things, he insists, it isn't about profit. It's about improving the public health system" (Cairney 2000b: 409). Robert Evans and his colleagues point to this statement and say "HRG is not a registered charity" and that "the critical point that cannot be over-emphasized is that the very powerful incentive driving for-profit organizations is to make profit. Period. It is not to improve the efficiency of the health care system, or to provide high quality care, or to advance the health of the population" (Evans et al. 2000: 35).
748. Maude Barlow points out that Bill 11 would not have been possible without the complicity of the federal government (Barlow 2002: 127). Thousands of

individuals protested Bill 11 as did organizations such as the Canadian Health Coalition, Consumers' Association of Canada, Alberta's Friends of Medicare, Alberta's Catholic hospitals, the Raging Grannies, unions, and municipal governments. The Alberta Medical Association opposed this Bill saying that "the province needs to focus on providing the public health system with adequate resources...we don't believe this bill actually protects anything and that it does not get to the root of the problems we have having in terms of providing services to our patients" (Cairney 2000a: 1606). "Dr. Dennis Modry, head of the AMA's section of cardiovascular and thoracic surgeons and a longtime critic of medicare, says the province's 20 cardiovascular and thoracic surgeons disagree with the AMA and may quit the association over the issue. 'With respect to Bill 11, we applaud the way in which the provincial government is looking for new, creative and innovative solutions to improving our health care system, in response to the federal health minister's challenge to the provinces to develop new ways of improving health care within the constraints of the Canada Health Act,' Modry said in a statement issued shortly after the AMA criticized the bill" (Cairney 2000a: 1607).

749. The Canadian Health Coalition requested an investigation into Liberal Senator Michael Kirby's potential conflict of interest as the author of a Senate report advocating for increasing competition in the health care system and as a board member of Extencicare (Canada) Inc. Kirby holds stock and stock options worth more than \$1 million in this company which runs nursing homes and long-term care facilities (McGregor 2004).
750. In late April 2004 the Health Minister Pierre Pettigrew made a number of controversial statements that "strongly suggest that the health minister will no longer use federal fiscal muscle to enforce the *Canada Health Act*" (Grieshaber-Otto and Sinclair 2004: 121). After a scolding from the Prime Minister Paul Martin, Pettigrew issued a public statement to do damage control that read, in part, "Unfortunately, I now realize that I have left the impression that I favour increased private delivery within the public health system. That was in no way my intent, nor is that the intent of the government of Canada" (Kennedy 2004). A new Health Minister, Ujjal Dosanjh, named in July 2004, has been criticized for his "laughably loose grip on his federal health portfolio" (Travers 2004).
751. Ancillary services include food preparation, cleaning, and maintenance services. These have been increasingly contracted out to for-profit companies by Canada's not-for-profit hospitals. These services are perceived to be relatively easy to assess as to whether the contracts are being fulfilled ("the laundry is either clean or it is not") and there are multiple vendors if a current contractor is unsatisfactory (Romanow 2002: 6). The obvious disadvantage from a population health perspective is that out-sourcing to for-profit corporations often means the loss of better paying, unionized jobs.
752. Direct health care services involve medical, diagnostic, and surgical care. The argument against for-profit direct health care services is that "if services are of poor quality, it is going to be much harder to find a replacement once public facilities have stopped providing the services—the capacity that existed in the public system will have been lost....In effect, these facilities 'cream-off' those services that can be easily and more inexpensively provided on a volume basis, such as cataract surgery and hernia repair. This leaves the public system to provide the more complicated and expensive services from which it is more

difficult to control cost per case. But if something goes wrong with a patient after discharge from a private facility—as a result, for example, of a post-operative infection or medical error—then the patient will likely have to be returned to a public hospital for treatment insofar as private facilities generally do not have the capacity to treat individuals on an intensive care basis” (Romanow 2002: 7).

753. The most exhaustive accounting of privatization initiatives is available from union sources such as (Canadian Union of Public Employees 2000) and advocacy groups for publicly funded health care such Canadian Coalition for Health, Canadian Center for Policy Alternatives, and Council of Canadians (Armstrong, Armstrong, and Fuller 2000; Grieshaber-Otto and Sinclair 2004). A sign that perhaps the privatization pendulum might be starting to swing in another direction is a Canadian Press report in July 2004 that Ontario was engaged in “secret talks” to strike back “at the creeping privatization of health care by preparing to buy out seven private clinics and bring them into the public sector” (Bueckert 2004b).
754. This is illustrated by the historical alliance between the Canadian Medical Association and the Canadian Health Insurance Association (CHIA), representing 120 companies, to fight national medical insurance in the 1960’s. It is interesting to note that Alberta, Ontario, and British Columbia were the provinces organizing against Medicare and that much of the rhetoric is the same after 40 years. For example: “...the CMA-CHIA alliance continued to attack the plan, especially the principle of universality—what the CMA-CHIA referred to as a system based on ‘compulsion.’ Under Ottawa’s proposed medicare scheme, the alliance warned, Canadians would no longer have the freedom to choose whether or not they would be insured or who would insure them, a freedom viewed by the alliance as a fundamental tenet of any free-enterprise, democratic society. A patient’s freedom to make ‘private arrangements’ with his or her own doctor would be seriously impaired, charged the alliance, and instead of having over 120 private insurers to choose from, Canadians would be forced to insure under a single government ‘monopoly’ (Fuller 1998: 63-64).
755. “Far from trying to minimize the cost of administrative overhead, and match premiums as closely as possible to benefit systems, private insurers refer to the rate of benefit payment as the ‘loss ratio’ and try to *maximize* the difference between premium revenue and payout. That difference is the outcome of the insurance sector” (Evans 1999: 39).
756. An analysis of Paul “The Man Who Killed Big Government” Martin’s reign since he became Finance Minister in November 1993 by the Canadian Center for Policy Alternatives makes a compelling case that Martin implemented the Washington Consensus favored by Reagan/Thatcher/Mulroney. The massive withdrawal of federal funds in the 1995 budget cuts “triggered cascading devolution, from provinces to municipal governments. Downloading was accomplished by off-loading, shifting services from public to private provision, or eliminating services” (Yalnizyan 2004: 3). The “revolutionary” aspect of this massive downsizing in the Canadian context was “the notion that no program was *a priori* a fundamental element of the public good. Everything was up for review, and could be classified as no longer “core” to the mission and purpose of government” (Yalnizyan 2004). The defining features of this revolution are 1) reduce the size of government 2) increase reliance on trade 3) attract more



foreign investment 4) lower inflation, lower the costs of borrowing money. The effects are 1) a vastly larger economy 2) declining investment in social and environmental programs and subsequent deepening poverty, more hunger, greater income inequalities, more people precariously housed or homeless, insecure access to clean drinking water, rising student debt and decreasing return on investment in education, rising problems of access to health care and 3) record budgetary surpluses at the federal level (Yalnizyan 2004: 5-10).

757. Two reasons that the Center for Policy Alternatives offer for why P3 hospitals should be viewed with caution is an estimate that P3 hospitals cost at least 10% more than their public sector equivalent and "serious problems of accountability, some of which have already become apparent during the planning of P3 hospitals in Ontario" (Auerbach et al. 2003: 1).
758. Working from the assumption that civil servants can, "through their influence on the economy, labor markets, social programs, and the health care system, affect many of the determinants of health and, through them, the health of populations," a survey was mailed to 153 federal and provincial civil servants in Canada (Lavis et al. 2003: 658). The overall response rate was 74% with similar response rates across federal and provincial levels of government and across three of the sectors: labor, social services, and health. The response rate from civil servants in finance departments was lower at 45% (Lavis et al. 2003: 659). Follow-up phone calls to civil servants in finance departments were often greeted with, "This isn't relevant to me" (Lavis et al. 2003: 662). "Civil servants in finance departments were outliers in many of their attitudes. They were less convinced than their counterparts in other sectors that health determinants should be considered in all major government initiatives. They were more supportive than their counterparts of improving economic prosperity rather than reducing inequalities. Civil servants in finance departments were less supportive than those in other sectors about investments in any type of policy action" (Lavis et al. 2003: 660). This group was "much less aware of ideas about the determinants of health in general and of research about the impact of specific health determinants on the health of populations" (Lavis et al. 2003: 662).
759. "There are no property rights protected in the Canadian Constitution. This omission was a conscious decision of the Trudeau Government to maintain the greatest amount of public policy flexibility. With its stringent protection of private property rights and its unique investor driven compensation process, the NAFTA creates property rights for foreign investors in Canada. In essence, the NAFTA has created a *de facto* amendment to the Canadian Charter of Rights and Freedoms except that these rights treat foreigners better than Canadian citizens" (Appleton 1999: 100-101).
760. It is significant that the three largest consortium or "summary" reports that the Commission on the Future of Health Care in Canada commissioned were on the themes of health human resources planning (Fooks et al. 2002), federal-provincial relations and health care (Lazar et al. 2002), and globalization and health framed as Canadian health care reform, trade treaties, and foreign policy (Campbell et al. 2002). The specific aspects of GATS and NAFTA that are highlighted to "warrant particular attention" include: "Expropriation and compensation: This NAFTA investment protection provision, which can be invoked directly by investors through investor-state dispute settlement, has been interpreted expansively and

could be used by investors to demand compensation for measures that expand Medicare coverage or restrict private-for-profit provision of health care services...Non-discrimination provisions: ...Where (national treatment or most-favored-nation treatment) apply, these provisions could be used to challenge policies that overtly favour local, community-based providers, or formally non-discriminatory policies that favour not-for-profit providers, if these adversely affect the competitive opportunities of foreign investors or service providers. Minimum standard of treatment: Seemingly innocuous, this NAFTA provision requiring investors to receive 'fair and equitable treatment and full protection and security' has been interpreted in unexpected ways. In effect, it provides foreign investors an exclusive right of administrative review that is directly enforceable through an international commercial arbitration process... Restrictions on domestic regulation: Negotiations are currently underway on the GATS to develop 'any necessary disciplines' to ensure that licensing, certification, technical standards and certain other domestic regulation of services and service providers is 'not more burdensome than necessary.' If such 'disciplines' were agreed to, they could provide WTO panels the ability to second-guess domestic regulators about the optimal or most efficient way of regulating health services" (Campbell et al. 2002: viii). Other provisions that are of concern are performance requirements, quantitative restrictions, provisions affecting monopolies and state enterprises, procurement rules, and intellectual property rights (Campbell et al. 2002: ix). Quantitative restrictions addresses cost-saving health care policies such as limiting the number of doctors or expensive diagnostic equipment that could be affected if Canada's GATS commitment in the realm of market access to health was changed (Campbell et al. 2002: viii).

761. "The genie that may be let out of the bottle is not one whose behaviour anyone can predict. Whatever assurances may be given about the limited and controllable effect of Alberta's initiative, there is no way for anyone to know whether they can be backed up. When the Alberta government's website responds to questions after NAFTA vulnerability with 'Absolutely not', their confidence is absolutely baseless. On the international stage, Alberta is not even a player...Canada, not Alberta, is signatory to the GATS; the WTO considers that failure to meet the terms of the Article 1.3 exemption anywhere in Canada is a Canadian failure, and opens all of Canada to foreign corporate competition in the hospital sector" (Evans et al. 2000: 32).
762. "The evidence on both sides of the debate is contestable and often based on interpretations about what the agreements 'might,' 'could,' or were 'intended to' mean. What is most frustrating is that the agreements can easily be read in a number of ways. There are only a limited number of legal decisions on the agreements and those decisions are often contradictory and open to many different interpretations. In terms of NAFTA, the situation is even more complicated because the decisions of its dispute resolution panels are not binding on each other....Oulellet has also argued that there is a risk that subsequent WTO agreements may contain provisions that run counter to some provisions of NAFTA...While NAFTA appears to protect the current health care system, there is some uncertainty around the question of whether it protects future changes that could made in the health care system" (Romanow 2002: 237).

763. "The goal of Canadian physicians, in partnership with their patients, is to provide the best health care possible. This Charter expresses what Canadian physicians need to achieve this goal." This passage cited in the dissertation is identical to the CMA Charter for Physicians, approved by the CMA Board of Directors, November 27, 1999, accessed September 25, 2004: [http://www.cma.ca/index.cfm/ci\\_id/3048/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/3048/la_id/1.htm)
764. "In keeping with the democratic rights accorded to all groups with respect to the terms and conditions of employment the CMA maintains that all individual medical practitioners should have the freedom to chose their method of remuneration. It is understood that certain payment methods may be associated with a defined service delivery model. Nevertheless, a physician's right to choose a payment method must be retained irrespective of the service delivery model in which he or she practices...Although the CMA does not endorse a particular payment method, fee-for-service remains the predominant option for the provision of insured medical services for Canadian physicians, according to the CMA Physician Resource Questionnaire" (Canadian Medical Association 2001: 2). The most common exceptions to fee-for-service are those physicians who work for Ontario's Health Service Organizations or Québec's Centres locaux de services communautaires (Lavis 2002: 3).
765. The "two bargains that underpin Medicare" are "private practice for physicians with (first dollar, one-tier) public (fee-for-service) payment; and private (not-for-profit) hospitals with (first-dollar, one-tier) public payment" (Lavis 2002: v).
766. The 2004 National Report Card was conducted between July 9 and 12, 2004 by surveying 1,057 adults by telephone.

**Table 9.1 Canada Medical Association Poll on Quality of Healthcare Services, 2001-2004\***

Question: "What letter/grade would you give to the overall quality of the healthcare services available to you and your family?"

Year	A	B	C	F
2004	18%	41%	30%	11%
2003	27%	40%	24%	9%
2002	23%	40%	28%	7%
2001	21%	44%	26%	9%

\*Source: (Ipsos-Reid Corporation 2004: 12)

767. "Canadians were asked on an open-ended basis to explain why they think it is that health care costs in Canada have grown faster than the economy overall for the past few years. Most often, respondents cite an aging population (23%) as the primary reason. Government mismanagement and misspent public funds follow as the second-most-common reason (18%) (Ipsos-Reid Corporation 2004: 18).
768. Sustainability was defined "as the likelihood that each aspect of Canada's public infrastructure would be available to the next generation of Canadians at the same level of quality and service as today. Among the tested aspects of Canada's public infrastructure, the sustainability of emergency services (83%), the educational system (60%) and water and sewage systems (58%) most often

earned grades in the A or B range. Fewer than 50% grade the sustainability of the Canada/ Québec Pension Plan (45%), the health care system (45%) or the roads and highways (45%) within the A or B range " (Ipsos-Reid Corporation 2004: 13).

769. "While the majority of Canadians support allocating federal surpluses to health care, they remain divided: on their willingness to pay higher taxes or out-of-pocket to either increase the range of services or to improve timeliness of care; on whether people should have the right to buy private health care to obtain timely access" (Canadian Medical Association 2004: 2).
770. The government of Alberta requested a "working understanding" from the federal government (under Prime Minister Jean Chrétien in 1996) that provided, among other things, "that the province would not be penalized, under the *Canada Health Act*, if its physicians worked and billed simultaneously in the public and private sectors" (Evans et al. 2000: 30).
771. The Ontario Medical Association's public information campaign materials (newspaper and radio ads) are available at:  
<http://www.oma.org/pcomm/media04/secondary2.html>
772. The Ontario Medical Association's eighteen recommendations to alleviate the physician shortage in the province include malpractice reform and elimination of "coercive billing" described as follows: "Eliminate all coercive measures, such as OHIP fee discounts and physician billing thresholds, which impact negatively on the provision of medical services. Currently, once a physician bills the government for services past a threshold, the government discounts a portion of each subsequent billing. This means that, for instance, after a family physician bills for services totaling \$350,000, the government cuts any further income to the physician by 33.3%. In the case of a specialist, that 33.3% is deducted after a threshold of \$430,000. Beyond that, there are more thresholds and even more penalties, up to 75%. It is recommended that these coercive measures stop, as it discourages the full and proper provision of medical services in communities across Ontario" Accessed September 25, 2004:  
[http://www.oma.org/pcomm/media04/physician\\_shortage.html](http://www.oma.org/pcomm/media04/physician_shortage.html)
773. "Systemic efforts to find such people in the U.S. health system, either in border states or in high-profile 'magnet' institutions, find remarkably small numbers. And the findings are consistent with survey responses in Canada. The 'streams of wealthy Canadians' heading south for care unavailable in Canada, are a media fiction, deliberately promoted by those on both sides of the border who have an economic interest in portraying Canadian health care as underfunded or simply inadequate. Highly publicized examples of Canadian provincial governments purchasing specific forms of care for their residents in the United States (such as the current situation in and Ontario for radiation therapy for some cancer patients) raises another set of issues... This is not two-tier medicine, but 'one tier with service imports'" (Evans et al. 2000: 47).
774. This is a complicated issue in that although physicians do leave Canada for other countries, especially the United States, the net loss is less than one percent per year. These losses do become "a significant political issue when they come from already hard to service (e.g. rural and remote) areas or from key, high profile disciplines such as neurosurgery or radiation oncology" (Barer and Webber 2000:

98). With the exception of 1994 and 1995, the number of international medical graduates entering Canada (in the period studied from 1975 to 1999) has exceeded the net loss of Canadian medical graduates (Barer and Webber 2000: 98). These authors point out that the “brain drain” of physicians to the United States is a phenomenon that “is no different in health care than virtually every occupation” (Barer and Webber 2000: 99). The concluding line of this article suggests “In light of the many serious policy issues related in one way or another to the flow of physicians into and out of Canada, it is time to move past emotive mythical claims about the threats to Canadian Medicare posed by mass migrations south so that attention can be focused on the real policy dilemmas” (Barer and Webber 2000: 100). Another important factor when looking at the history of the current perceived shortage of physicians in Canada is the cyclic nature of this discussion. In 1991 the Federal/Provincial Advisory Committee on Health Human Resources released a report recommending a reduction in medical school enrolment by 10% in response to a prevailing understanding was that Canada had too many physicians (Fooks et al. 2002: 1).

775. A comparison of media accounts of overcrowding in emergency departments in Canada and the United States during a flu epidemic showed some interesting differences. Major accounts in the *Washington Post*, *The New York Times*, and *ABC* used the overcrowding “as evidence that Canada’s universal health insurance program was critically flawed. The problems of Canadian emergency rooms, in short, indicted Canada’s medicare. The two major reports on the problem in the United States, by *USA Today* and *Time* magazine, did not, however, turn overcrowding in American ERs into an indictment of America’s non-universal health insurance system” (Marmor and Sullivan 2000: 15). Marmor and Sullivan draw attention, in particular, to Steven Pearlstein’s account in the *Washington Post*: “ ‘Most academic experts,’ wrote Pearlstein, ‘say that while more money might alleviate the shortage of advanced technology, hospital beds, and medical school slots, it will only be a matter of time before the demand for medical services once again overtakes the willingness of voters to pay for it.’ Pearlstein then quoted a Canadian ‘professor of health administration’ who claimed ‘the big problem’ is that ‘Canada has un-managed care,’ implying that Canada could avoid the apocalypse predicted by Pearlstein if it would import the techniques of managed care from the United States” (Marmor and Sullivan 2000: 15).
776. Poll data used in this article was not specifically attributed to the Canadian Medical Association. “Medical professionals” are cited generally in tracking decreased access in small towns and rural areas, Ontario Medical Association data are used to explain that “Whitby is one of 136 communities...not adequately served by family doctors,” and “The Canadian Medical Association estimates that the country requires 2,500 medical graduates annually but is producing only 2,200 a year” (Krauss 2004).
777. “A 2002 report from the Canadian Senate said that the actual number of family doctors had decreased only slightly in recent years but that the demands of an aging population were growing” (Krauss 2004). Alternative interpretations to the theme of demographics driving crisis may be found in Chapter 6 and by a comparison of expenditures for physician services in British Columbia from 1985-1986 to 1996-1997. “Total payments to fee-for-service physicians in British Columbia rose 86.3% for the study period. The increase was entirely accounted for by the combined effects of population growth (28.9%), aging (2.1%), and

general inflation (41.4%)...These findings suggest a form of 'homeostasis' in aggregate-level service use and cost. The supposed inflationary effects of population aging and increasing 'abuse of the system' by patients were not found" (Barer et al. 2004: 803).

778. Doctor (as he makes sure to display prominently) David Gratzner may be more dangerous, in the Canadian context, than his counter-part for regressive policies in the United States, Sally Satel. While Satel is associated with the American Enterprise Institute, Gratzner is a senior fellow at the Manhattan Institute's Center for Medical Progress, according to his website: <http://www.davidgratzner.com/>, accessed September 26, 2004. "The Manhattan Institute is a think tank whose mission is to develop and disseminate new ideas that foster greater economic choice and individual responsibility" (<http://www.manhattan-institute.org/>, accessed September 26, 2004. With echoes back to Edward Annis, Gratzner is the author of *Code Blue: Reviving Canada's Health Care System* (1999) and editor of *Better Medicine: Reforming Canadian Health Care* (2002). These two books are cited by the Royal Commission on the Future of Health Care in Canada as the references underpinning "some suggest that private for-profit delivery is more efficient than not-for profit delivery" (Romanow 2002: 7).
779. A discussion of interesting issues related to refusal of unwanted care may be found in (Jackman 2002: 2-4).
780. Right to receive care issues such as access to abortion, specific medical treatments, sign language interpretation, etc. may be found in (Jackman 2002; Greschner 2002).
781. "Overall, courts have been unusually insensitive to the enormous cost ramifications of invalidating provincial rationing schemes for physician services. Although, as noted previously, the jurisprudential foundations of the doctors' victories are now shaky, the general judicial fondness for doctors' claims may carry over into new challenges brought by doctors to preserve their dominant position with the health care system. For instance, it is not unrealistic to expect challenges if a regional health authority required all doctors in its area to be paid by capitation or employment contracts, rather than permitting 'fee for service' arrangements" (Greschner 2002: 15).
782. Descriptions of this case seem to be fairly uniform: it "could overturn medicare" (Flood 2004), "destroy the very basis of universal medicare" (Bueckert 2004a), and "shake Canadian health care to its core" (Sullivan 2004).
783. The *Canadian Medical Association Journal* suggested that the "subtext" of this legal drama is "Chaoulli's zeal and tenacity in preparing and fighting this case almost single-handedly" (Pinker 2000: 1348). Chaoulli "is incensed at what he considers a provincial monopoly over health care" which he considers to be "antidemocratic" (Pinker 1999a: 1305). "He is emphatic that he can provide the best care for his patients within the context of private medicine, and he is prepared to defend his principles. 'I have a duty to provide a good service to my patients. No one should interfere. No one should block me when I want to help my patients and alleviate their pain'" (Pinker 1999a: 1306). Chaoulli has been informed that it is illegal for him to use his "mobile emergency room" in a van, which "is equipped with an x-ray machine, darkroom, siren, portable

electrocardiograph machine and intravenous equipment" (Pinker 1999a: 1305). He opted out of Medicare between 1996 and 1998 and then rejoined the system but seems to spend most of his time on his "crusade." Chaoulli said, "If you want to prove something, you have to go far. If I lose the case, it will not only be total bankruptcy for me, but a state monopoly on health care forever. How come such a big issue for the country rests on the shoulders of two citizens?" (Pinker 2000: 1348). He once went on a hunger strike over the right to set up a private medical business. "He is being supported by some companies in the health-care field" (Bueckert 2004c). What this exactly means is unclear—the claim is also made that he is "financing his expenses out of his own pocket" (Lemieux 2004).

784. George Zeliotis "says he's a casualty of the existing system. The 67-year-old retired businessman waited almost a year for hip-replacement surgery in 1997" (Pinker 1999a: 1305).
785. In the Québec Superior Court case of *Chaoulli v. Québec* (2000), the plaintiffs alleged "that the lack of timely access to provincially insured health care services, because of financial and human resource constraints within the public system, coupled with legislative restrictions on access to private care, amounted to a violation of the section 7 right to life, liberty and security of the person.... On appeal, Justice Piché's decision was upheld by the Québec Court of Appeals in three concurring judgments (Chaoulli 2002). Justice Delisle found that access to publicly funded health care was a fundamental right under section 7. However, he said that the right to purchase private health insurance was an economic claim, which was not fundamental to human life" (Jackman 2002: 7).
786. Marvin Storrow presented the argument for the interveners (Cambie Surgeries, et al). "The people that we act for here are 14 clinics from British Columbia, two of which are diagnostic, the other 12 are surgeries. We act for the British Columbia Anaesthesiologists Society and the British Columbia Orthopaedic Association. Between them, they perform about 30,000 procedures a year in British Columbia. In British Columbia, we have about 80,000 people on our wait lists, likely, a very high percentage of the procedures performed by our clients would be added to the wait lists in British Columbia if our clients weren't doing what they doing so, in a sense, they're making the public system a bit easier" (*Chaoulli v. Quebec* 2004: 57-58).
787. This public response was provoked by an analysis done by Colleen Flood (2004): "The senators and the CMA appear to be taking the middle ground, but behind their moderate stance is a serious attack on universal access... In pursuit of a policy goal of waiting-time guarantees, both the Senate and the CMA are willing to sacrifice universal health care from coast to coast."
788. Martha Jackman argued: "As the Attorney General of Québec pointed out, the particular irony in this case is that, were the impugned provision struck down, it's hardly unlikely that Mr. Zeliotis, elderly and self-employed, could in fact obtain what he's seeking, that is, private health insurance, either because it would be prohibitively expensive for him or because no private insurer would be willing to offer it to him" (*Chaoulli v. Quebec* 2004: 119).
789. In addition to the neoliberal ideologues, Machiavellian politicians, and rapacious corporate interests identified earlier, special mention is made here of a *Financial*

*Post* story that dismissed the Canada Health Coalition as “the poverty industry,” used Fraser Institute data uncritically, and reframed the discourse as “decriminalizing private health care (including private insurance) and putting “monopoly on trial” (Lemieux 2004).

790. Given that the logic of neoliberal reforms are so often legitimized with Margaret Thatcher’s slogan of “There Is No Alternative” (Evans et al. 2000: 39) contributing to a “myth of powerlessness” and a “cult of impotency” (McQuaig 1998), it seems important to begin this concluding chapter with an illustration that reminds of alternative forms of organizing communal life that have worked for thousands of years.
791. The phenomenon of educational capital, as well as more general forms of cultural capital, is from (Bourdieu 1984).
792. Physicians for a National Health Program’s website is <http://www.pnhp.org/>
793. In an anecdote popular on the conference circuit, an American health policy analyst who has ascended to heaven asks God, ‘Will there ever be universal health insurance coverage in the United States?’ ‘Perhaps,’ sighs God, ‘but not in my lifetime. This paper argues that this tale accurately describes the prospect of covering the uninsured in this country. Neither moral sentiments among a majority of U.S. political leaders, economic self-interest among those who would have to pay for universal health insurance, nor political pressure from the uninsured and likely-to-be-uninsured will provide a sufficiently strong imperative to move this country toward universal coverage soon, if ever” (Reinhardt 2003: W3-376).
794. This survey of 3,188 randomly sampled physicians from the American Medical Association Physician Masterfile has a response rate of 60%. While 49% of the physicians who responded supported legislation to establish national health insurance only 26% supported a single federal payer system (Ackermann and Carroll 2003: 797). Primary care physicians, those reporting that at least 20% of their patients had Medicaid, and physicians practicing in a nonprivate setting or inner-city locations were statistically more likely to support government legislation to establish national health insurance (Ackermann and Carroll 2003: 795).
795. A random sample of 1,787 physicians from the American Medical Association Masterfile in Massachusetts conducted by physicians associated with Physicians for a National Health Program had a response rate of 50.6%. “When asked which structure would provide the best care for the most people for a fixed amount of money, 63.5% of physicians chose a single-payer system; 10.7%, managed care; and 25.8%, a fee-for-service system. Only 51.9% believed that most physician colleagues would support a single-payer system.” (McCormick et al. 2004: 300). It is not clear to me whether an intellectual acknowledgement of which system “would provide the best care for the most people for a fixed amount of people” actually translated into “support” for a single-payer system.
796. An illustration of this is Paul Starr’s treatment of Richard Brown (Starr 1982: 227-228).



797. The Physicians' Working Group for Single-Payer Health Insurance's proposal was written by Steffie Woolhandler, David Himmelstein, Marcia Angell, and Quentin Young and endorsed by 7,784 additional signatures on the Physicians for a National Health Program website (2003: 798). An important physicians' organization in Canada that described itself as "a voice for socially concerned physicians" is the Medical Reform Group. (Website: <http://www.hwcn.org/link/mrg/>). Founded in 1979, this group is currently comprised of approximately 300 physicians and medical students who believe "that health is political and social as well as medical in nature and that health care is a right" (Medical Reform Group 2004: 6).
798. (Bush 2003) "State of the Union" address by President George W. Bush delivered on January 28, 2003.  
<http://www.whitehouse.gov/news/releases/2003/01/20030128-19.html>
799. The AMA warns: "Policy makers should be aware of the siren song of single-payer advocates. Experience with these systems has exposed the many drawbacks for patients and physicians....Tax credits combined with enrolling uninsured Medicaid-eligible individuals would result in coverage for approximately 95% of the US population. This level of coverage compares favorably with that of other industrialized countries that have achieved 'universal' coverage (Palmisano, Emmons, and Wozniak 2004: 2240). Other industrialized countries might be surprised to find that they have "universal" coverage rather than universal coverage.
800. Summing up the rush to privatize in Alberta described in Chapter Nine, (Evans et al. 2000: 37) observe: "Stripped to the bone, the Alberta proposal appears to be little more than taking lousy odds on a very small profit, and gambling with the health of Canada's health care system, for the sake of a few Alberta health care providers who would stand to gain considerably in the short term."
801. "As technology improves, 'it would be possible for a small hospital in the United States to digitize an image, put it on their server and have a pathologist anywhere in the world, such as India, provide a diagnosis,'" said Ronald S. Weinstein, professor and head of pathology at the University of Arizona College of Medicine in Tucson and director of the Arizona Telemedicine Program...Someday, said Dr. Weinstein, who is president of the American Telemedicine Association, a professional society, there may be virtual universities that can train doctors in foreign countries to meet American requirements. 'The concept of boundary-limited medical education and licensure will fade in time,' he said (Pollack 2003).

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