

BOOK REVIEW

Health care under the knife: moving beyond capitalism for our health*

Martin Donohoe, MD, FACP

Reviewer's note: Authors of each subsection are a who's who of social medicine, many of whom I count as mentors and friends (including Waitzkin), and as such I am neither a disinterested nor unbiased reviewer. Dr. Waitzkin¹ also endorsed my own book² with a back of the cover blurb (as did others), although my (perhaps) fragile ego and my mother's equally glowing endorsement compel me to write this off to my literary skills, rather than our friendship! I have no financial arrangements with any of the authors. I have critically assessed the volume with recognition of my subjective biases as best as humanly possible. Furthermore, I have supplemented my review with my own critiques of contemporary medicine and suggestions for improving health care for all.

Health Care Under the Knife presents a comprehensive overview of the ills consequent to the financialization/capitalization of health care,

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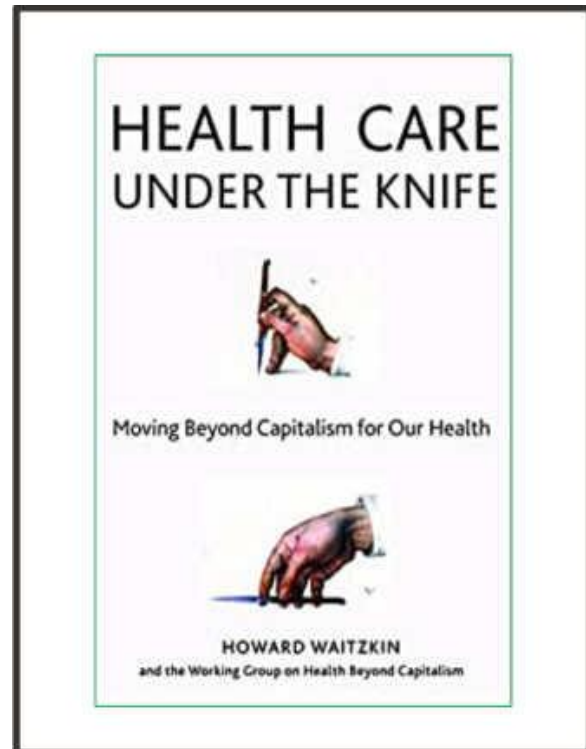
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**Health care under the knife: moving beyond capitalism for our health*, Howard Waitzkin and the Working Group on Health Beyond Capitalism; New York; 2018; Monthly Review Press, with Additional Commentary



focusing on the United States. The work consists of five sections: social work and medical class; the medical-industrial complex in the age of financialization; neoliberalism and health care reform; the trajectory of imperialism's health component; and the road ahead.

This book would be useful for undergraduates, graduate health professions students, business students seeking an alternative perspective on the business of health care, and members of the general public with a college-level education and an interest in how health is defined, health care delivered, and the forces which interfere with human health and development while proclaiming to do the opposite. The book, which has been endorsed by prominent researchers, educators, policymakers, and activists, would make a valuable textbook for undergraduate and graduate

level courses, and many of the individual chapters could stand alone, although review articles by many of the authors published in the peer-reviewed scientific literature could suffice equally well if not better, if such an approach is more appropriate to the curriculum.

The highlight of part one is Dr. Matthew Anderson's⁵ discussion of the proletarianization of health care workers, critiquing initiatives such as the patient-centered medical home and pay-for-performance and other so-called "quality metrics." Anderson criticizes poorly-developed systems of electronic medical records (EMRs), with their emphasis on capturing billing codes to maximize reimbursement and failure to link with each other. These systems and their inherent demands on providers' time have distanced practitioners from actual patient care and contributed to an epidemic of burnout, which when combined with doctors' loss of control over health care lead to a syndrome of alienation, a major reason why a growing number of physicians (especially those in primary care) regret their career choice, retire early, and suffer from high rates of depression and suicide. None of this bodes well for our growing and aging population, given predictions of a growing dearth of physicians to meet the nation's medical needs over the coming decades. EMRs have also facilitated the malignant proliferation of excessively lengthy, templated chart notes, in which patients' individual stories become lost and the nuances of diagnosis and medical decision-making are mired in the quicksand of clinically unnecessary (and often meaningless) dot phrases.

The chapter in which Waitzkin interviews Physician for a National Health Plan co-founders and single payer health policy experts is somewhat unfocused, and would have been better served by augmenting, later in the book, the chapter by these researcher-physicians on the ethical and economic rationales behind single payer, with more details on how it would be financed (indeed, it would be cost-saving) and the expected gains in decreased morbidity and mortality.

Part two covers the medical industrial complex in the era of financialization, including the monopolization of health care (as witnessed by the mergers of major hospital systems, insurance companies, and pharmaceutical and medical device manufacturing entities). It includes a discussion of how not-for-profit entities are acting more and

more like for-profit organizations. Indeed, in 2013, seven of the ten most profitable acute care hospitals in the United States were officially non-profits.⁴ Since nationwide, tax-exempt hospitals vary markedly in the level of community benefits they provide, with most of their benefit-related expenditures allocated to patient care services and little spent on community health improvement,⁵ we should question their tax-exempt status and/or require them to reinvest more of their profits into health care (while justly cutting the exorbitant salaries paid to CEOs and top-level administrators -- Indeed, I wistfully remember the era when the most respected physicians at medical schools were the most astute clinicians, teachers, and researchers, rather than those who have largely traded in their scrubs and lab coats for the capitalist manifesto preached by "health care MBA" degree programs and weekend "health care business seminars," in the process increasing their salary and institutional prestige but turning them into automatons reliant more upon the metrics and marketing schemes required to augment institutional profits than upon the scientific and humanitarian drives that, one would like to believe, led many of them into medicine in the first place.

Joel Lexchin's chapter on the machinations employed by bi pharma singles out an industry particularly notable, along with tobacco and soda companies, for making egregious profits off the backs of the ill.⁶ Drug companies spend much more on marketing than on research and development (much of which is conducted by independent scientists, using federal funds), focus on nichebusters rather than novel blockbusters, and pay little attention to the "neglected tropical diseases" which cause vast suffering and death in the developing world. Through cherry picking and selective publication of data, suppression of unfavorable results, and halting trials for financial rather than clinical reasons, they present providers with an inaccurate and potentially dangerous perspective on their drugs' clinical utilities. Those who withhold clinically-relevant information leading to patient illness, injury, or death should be punished not just by fines, but by serious jail time.

Alternative models of drug development (like the Mario Negri Institute in Italy) and legislation (such as the Federal Research Public Access Act, pending in Congress) would better meet society's

needs. Even so, only when drug development and distribution are treated as public benefits, supported by taxes and distributed based on need, will there be a just pharmacopeia. Capitalists will argue that without the profit motive, important research would not get done, but given the funding to conduct basic science and clinical research, almost all scientists would be delighted to focus on developing agents that will cure cancer or HIV or malaria, rather than altering a chemical moiety to create yet another H2 blocker. Lexchin's topic is especially timely given massive increases in prices for life-saving drugs like insulin, metformin, doxycycline, colchicine, propranolol, epinephrine, and hepatitis C medications.

Part three covers neoliberalism and health reform. Waitzkin and Ida Hellender criticize Obamacare for its structure, financial flows which benefit private insurance corporations and managed care companies, administrative bloat, failure to cover everyone, and ultimately, its financial unsustainability. Single payer would alleviate many of these deficiencies, and is now favored by a majority of people in the United States (when pollsters do not demonize it with terms like "socialized medicine") and medical school deans. Its prospects have become more realistic thanks to a growing recognition by patients that the current system is broken, and to 2020 presidential candidates, such as Bernie Sanders, who are vocal supporters. This section also covers the support of austerity measures (in Greece, Spain, and England) by conservative politicians and international financial institutions, resulting in a weakening of the social and health care safety nets, which underscores the need for strong national and international social movements to treat health care as a human right. This will require recognition of the primacy of the doctor-patient relationship, something that is difficult given the proletarianization of medicine.

Part four covers philanthropy, including how philanthrocapitalism, in conjunction with policies of international financial institutions like the World Trade Organization, World Bank, and International Monetary Fund, perpetuates a neoliberal, profit- and technology-driven approach to health care and its many socioeconomic correlates, including education and food, agriculture, and water policy. When a few wealthy individuals dictate public policy through their

charities (such as Bill Gates through his eponymous foundation), proposed "solutions" reinforce the idea that "the rich know best" and help to consolidate the power of multinational corporations while stifling democratic, bottom-up approaches, which are often much more effective (and cost-effective). Chapter authors Birn and Richter rightly ask why mega-billionaires are celebrated for their philanthropy rather than scrutinized for their business practices⁷, although this is beginning to happen viz a viz technology giants being investigated and fined for privacy violations and promulgation of misinformation. Furthermore, the Sackler family, which has donated millions to museums and other institutions, is facing criminal investigations and lawsuits for its aggressive marketing of Oxycontin, a major contributor to the current national opioid epidemic.

A brief discussion of the tobacco and soda industries' marketing techniques,⁸ often under the guise of philanthropy, would have been helpful, as well as the role of the Gates Foundation and large agribusiness in promoting genetically-modified (GM) crops to the developing world under the ruse that they will eliminate world hunger and increase yields as the climate warms. In reality, these crops pose myriad environmental and health risks and are largely designed to withstand an increasing array of herbicides and pesticides, unsurprisingly sold by the same companies that sell the GM seeds.⁹ Indeed, no commercially available GM crop exists that is drought-resistant, salt- or flood-tolerant, or which increases yields. Furthermore, GM crops undermine food and nutritional security, food sovereignty, and food democracy, and marginalize effective conventional breeding techniques that have proven effective, consolidating corporate control of agriculture in the hands of a few multinational corporations, while transmogrifying farmers into bio-serfs. The United Nation's Food and Agriculture Organization has stated there is already enough food produced to provide over 2700 calories per day to every person on the planet. Ironically, 1/3 of world food production is wasted. Solving world hunger requires political and social will, not high technology interventions, a point driven home by the fact that one week of developed world farm subsidies equals the annual cost of food aid necessary to eliminate world hunger.

Another small quibble is that Birn and Richter find the tax deductibility of philanthropic donations an affront to democracy and claim that people living on modest incomes do not receive tax breaks for their contributions, which to some extent depends on how you define modest income, as such tax breaks are helpful to members of the U.S. middle class and may promote charitable giving.

Part five, “The Road Ahead,” describes resistance to the social order in El Salvador and Mexico; returns to the failures of Obamacare and argues for a single payer health care system in the U.S.; and briefly describes the roles played by deforestation and the rise of megafarms in supporting epidemics of ebola and zika viruses, along with various types of influenza, respectively. The authors, however, neglect to mention that overuse of agricultural antibiotics is the major contributor the rise of food-borne bacterial diseases. The flint/lead poisoning water crisis is briefly noted, without an adequate explanation for the uninitiated of the history and health consequences of lead poisoning in the U.S. and worldwide, to provide some context. I would have appreciated a more detailed discussion of the myriad environmental contributors to human health, especially climate change and air and water pollution.

The chapter by Carl Ratner on pathologizing normalcy briefly notes how certain aspects of the political, criminal justice, and educational systems in the U.S. are pathological, but lacks detail. Furthermore, Ratner minimizes the admittedly overhyped benefits of many psychotropic medications, stating, for instance, that such drugs “desensitize or tranquilize individuals to social stressors and make them less perceptible.” Ratner implies that drugs used for everything from depression to anxiety to schizophrenia are prescribed to divert patients’ attention from the misery caused by social stressors, and as such ignores much research about the neurochemical correlates of psychiatric illnesses. On the other hand, in discussing “pathologically normal” violence and war, the author posits that “presidents and secretaries of defense who authorize and plan wars are not mentally ill.” I and others¹⁰ would argue instead, that militarism is a psychosocial disease, and such individuals are its vectors (and in

the extreme could be the cause of an apocalyptic annihilation of humanity).

The final chapter in the book, “Moving Beyond Capitalism for our Health,” briefly notes a few social justice movements of the 20th Century (e.g., the medical civil rights movement of the Medical Committee on Human Rights; physician strikes in El Salvador, Spain, and the United Kingdom; the failures of Hugo Chavez’s Venezuelan health care policies), but the treatment is cursory and requires prior understanding and context for full understanding, which was likely excluded due to limitations on space. Authors Adam Gaffney and Waitzkin support a shift towards constituent power, referencing Gavin Mooney’s support of “citizens’ juries in which randomly selected community members participate in a process of informed, deliberative decision making on community health issues...” While democratization of health care and a shift toward constituent influence and power is desirable, the importance of expert voices, especially health care providers and health policy experts, should not be marginalized; rather it should be emphasized, as illustrated by the persistent power of the anti-scientific, anti-vaccination movement, which has contributed significantly to the current measles epidemic. Through it all, providers should always retain their focus on patients’ stories, which not only provide helpful diagnostic information and hints regarding potentially useful therapies, but also promote doctor-patient bonding and revitalize the human element of medicine in an era where charting is dominated by cut-and-pasted dot phrases and lists of diagnoses designed more for billing than for patient care.¹¹

While the book’s length limits the number of topics that can be covered, and the space available for each topic, because of my own interests and biases, I would have like to have seen more of the following (note that many of these topics are relevant to the overarching topic of social medicine, *Health Care Under the Knife* is not intended as a textbook of social medicine, and indeed some of these will be covered in an upcoming social medicine textbook edited by Waitzkin and Anderson):

A chapter devoted to some of the heroes of social medicine, such as Rudolph Virchow, Thomas Hodgkin, Florence Nightingale, Alice

Hamilton, Albert Schweitzer, and Salvador Allende.

- More details on how a single payer national health plan would be implemented and paid for¹², including a discussion of job retraining for insurance company employees, coders, and myriad other administrators (similar to the process necessary for coal miners and oilmen and women to transition to green energy jobs, or tobacco farmers to raising food crops).
- More attention to the details of how corporate malfeasance impacts public health.¹³ This might include a discussion of how social marketing can counter the aggressive and influential campaigns of dirty energy, tobacco, soda, and food processing conglomerates, big pharma, and the health insurance industry.
- Mention of how academic institutions, traditionally the providers of last resort for the underserved and the setting where students and trainees learn principles of medical ethics and evidence-based practice, have compromised their core missions through the development of concierge practices catering to the uber-wealthy, setting up a two-tiered system of health care which often promotes tests which not only lack evidence, but can cause harm (yet are highly reimbursable).
- The worldwide refugee/migrant crisis and undocumented immigrants in the United States, including drivers of migration, health consequences, and policy approaches to alleviate suffering and promote societal acceptance and integration.
- The rise of fake news, its effects on social policy and democracy, and standards for verifying and interpreting the claims of journalists versus public relations flacks, racists, misogynists, and others obfuscating political discourse.¹⁴
- How the social, legal, educational, and political marginalization of women, along with violence against women, affect health care,¹⁵ including a discussion of the MeToo movement.
- The rise of racism, supported by historical discrimination and ongoing unjust economic and social policies, and fueled by ultranationalist, conservative, demagogues like Donald Trump, Rodrigo Duterte, and Jair Bolsonaro, whose self-professed

“Christianity” perverts the fundamentally socialist teachings of Jesus Christ. These “leaders” (who sow discord and chaos) are enabled by complicit lawmakers and religious organizations, a lackluster press, and others.¹⁶ Such a discussion should also note the role played by the BlackLivesMatter movement.

- The consequences of war and militarism for human health, including physical and mental suffering, refugees, and the diversion of trillions of dollars away from pressing societal needs.¹⁷
- Most important, attention to rationale and process by which the ideas of social medicine can be incorporated into the curricula beginning with primary school health courses and continuing all the way through post-doctoral training and continuing education requirements.^{18,19,20} Regrettably, schools of medicine (and even public health) tend to marginalize many of the concepts covered in Waitzkin’s book, as well as others noted herein.²¹

In conclusion, Waitzkin’s book is a very informative and readable volume for those new to the evils of market-based health care and those hoping to consolidate their knowledge, and as such I highly recommend it.²²

Reference

- 1 The prolific Dr. Waitzkin also authored the following books: *The exploitation of illness in capitalist society* (The Bobbs-Merrill studies in sociology) (Indianapolis; Bobbs-Merrill; 1974); *The Politics of Medical Encounters: How Patients and Doctors Deal With Social Problems* (New Haven; Yale University Press; 1993); *The Second Sickness: Contradictions of Capitalist Health Care* (Oxford; Rowman and Littlefield; 2000), *At the Front Lines of Medicine: How the Health Care System Alienates Doctors and Mistreats Patients...and What We Can Do About It* (Oxford; Rowman and Littlefield; 2001); and *Medicine and Public Health at the End of Empire* (Colorado; Paradigm Publishers; 2011), previously reviewed in this journal (see Anderson M. Howard Waitzkin’s *Medicine and Public Health at the End of Empire*. *Social Medicine* 2012;7(1):1-3. Available at <http://www.socialmedicine.info/index.php/socialmedicine/article/view/660>. Accessed 4-26-19).

- 2 Donohoe MT (Ed). Public Health and Social Justice (San Francisco: Jossey/Bass, 2013). Available at <http://www.josseybass.com/WileyCDA/WileyTitle/productCd-111808814X.html>. Table of contents and endorsements at <http://phsj.org/public-health-and-social-justice-reader/>.
- 3 Founder of the Social Medicine Portal (see <http://www.socialmedicine.org/>) and editor of this journal.
- 4 Bail G, Anderson GF. A More Detailed Understanding Of Factors Associated With Hospital Profitability. *Health Affairs* 2016;35(5). Available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1193>. Accessed 4-19-19.
- 5 Young GJ, Chou C-H, Alexander J, Shoou-Yih DL, Raver E. Provision of Community Benefits by Tax-Exempt U.S. Hospitals. *N Engl J Med* 2013; 368:1519-1527. Available at <https://www.nejm.org/doi/full/10.1056/NEJMsa1210239>. Accessed 4-19-19. DOI: 10.1056/NEJMsa1210239
- 6 For those interested in more in-depth analysis of pharmaceutical company malfeasance, I recommend Donald Light's *The risks of prescription drugs* and his website <http://www.pharmamyths.net/index.htm>. Lexchin's *Private profits versus public policy: the pharmaceutical industry and the Canadian state* and *Doctors in denial: why big pharma and the Canadian medical profession are too close for comfort* illustrate how similar wrongdoings occur north of our border.
- 7 The same can be said of high-level mobsters and drug traffickers, who are often praised by their communities and escape capture and prosecution due to their largesse directed at schools, parks, etc.
- 8 See Wiist W. *The Bottom Line or Public Health: Tactics Corporations Use to Influence Health and Health Policy, and What We Can Do to Counter Them* (2010; Oxford University Press). See also Nick Freudenberg's *Corporations and health watch*, available at <http://www.corporationsandhealth.org/>. Accessed 4-26-19.
- 9 See GM Watch, among other sources, for more details. Available at <https://www.gmwatch.org/en/>. Accessed 4-26-19
- 10 Coulter NA. Militarism: a psychosocial disease. *Med War*. 1992 Jan-Mar;8(1):7-17.
- 11 For a detailed discussion of how literature, art, and photography can be utilized in medical education and training to teach social justice concepts and encourage activism, including specific curricular suggestions, see Donohoe MT. *Stories and Society: Using Literature to Teach Medical Students about Public Health and Social Justice*. *International J of the Creative Arts in Interdisciplinary Practice (IJCAIP)* 2009 (Issue 8). Available at <http://ijcaip.com/archives/IJCAIP-8-Donohoe.html>. Accessed 4-26-19.
- 12 See presentations, articles, and policy papers on the Physicians for a National Health Plan website. Available at <https://pnhp.org/>. Accessed 4-26-19.
- 13 See numerous open-access slide shows and articles on the Activism and Education page (among others) of the Public Health and Social Justice website. Available at <http://www.publichealthandsocialjustice.org> or <http://www.phsj.org>. Accessed 4-26-19.
- 14 Examples of good progressive scientific publishing and journalism include medical journals such as *The Lancet* and *Social Medicine* (published in English and Spanish, see <http://www.socialmedicine.info/index.php/socialmedicine>); magazines like *Mother Jones*, *Harpers*, and the *New Yorker*: muckraking investigative journalists like those at *ProPublica* (see <https://www.propublica.org/>); trusted veteran pundits like *Democracy Now's* Amy Goodman (see <https://www.democracynow.org/>), Jim Hightower (see <http://jimhightower.com/>), and Bill Moyers (see <https://billmoyers.com/>); and comedians like John Stewart, Stephen Colbert, Seth Meyers, John Oliver, Bill Maher, Trevor Noah, Michelle Wolf, and Samantha Bee.
- 15 See numerous open-access slide shows and articles on the Women's Health page of the Public Health and Social Justice website. Available at <https://phsj.org/womens-health/>. Accessed 4-26-19.
- 16 Donohoe MT. *Complicit. Prescription for Justice* (cable access television program). Available at <https://www.youtube.com/channel/UCJt34I9c5vT2RpZitkg6Im2A/videos> (see episode 8) and in podcast form at <https://kboo.fm/program/prescription-justice>. Updated print version in press for *Social Medicine* (2019).
- 17 For a discussion of how health care curricula can incorporate the ideas and competencies relevant to the prevention of war, see *Role of public health in*



- the prevention of war: rationale and competencies. *Am J Publ Hlth* 2014(6):e34-e47 – Wiist W, Barker K, Arya N, Rohde J, Donohoe M, White S, Lubens P, Gorman G, Hagopian A. Article and supplemental material available through the American Journal of Public Health at <http://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2013.301778>.
- 18 Karnik A, Tschannerl A, Anderson MR. What is a social medicine doctor? *Social Medicine* 2015;9(2):56-62. Available at <http://www.socialmedicine.info/index.php/socialmedicine/article/view/837>. Accessed 4-26-19.
- 19 Donohoe MT, Schiff G. Call to Service: Social Justice Is a Public Health Issue. *AMA Journal of Ethics*;2014(September); 16(9):699-707. Available at <https://journalofethics.ama-assn.org/article/call-service-social-justice-public-health-issue/2014-09>. Accessed 4-26-19.
- 20 See also the People's Health Movement (<https://phmovement.org/>) and the People's Health Assembly (<https://phm-na.org/peoples-health-assembly/>). Accessed 4-26-19.
- 21 The Public Health and Social Justice website contains many frequently-updated, open-access slide shows, articles, syllabi, and links to over 1,000 websites/organizations. The site takes no advertising, actually costs me money to maintain, and welcomes new submissions. See <http://www.publichealthandsocialjustice.org> or <http://www.phsj.org>. Accessed 4-26-19.
- 22 For those interested in other books relevant to social medicine, see the list on the Social Medicine Portal at <http://www.socialmedicine.org/for-students/social-medicine-books/>.