This book will be based on extensive research into primary and secondary sources as well as interviews with physicians, public officials, and others with relevant experience and expertise. It will be written for the concerned public, policy makers, and above all, physicians, in the hopes of accelerating reform in the American health care system. It will also be of interest to academics, like bioethicists, public health experts, and medical historians whose disciplines I draw on.

1. Introduction. Medicine’s Social Contract, Its Negotiation, and Its Fulfillment

The book will open with a discussion of the need for an authentic “social contract between medicine and society,” a concept circulating in bioethics and medical reform circles. The lack of a well-conceived and faithfully fulfilled social contract is evidenced by out-of-control spending on health care--approaching 20 percent of the GDP--much of which is of questionable value and risky, while affordable high-value care is inaccessible to much of the low-income population. Literature coming out of the medical profession itself speaks with eloquence and anguish about a “broken” and “chaotic” health care system. For example, Otis Webb Brawley, chief medical and scientific officer and executive vice president of the American Cancer Society from 2007 to 2018, called his book How We Do Harm: A Doctor Breaks Ranks about Being Sick in America. Brawley tells of getting “furious” every time he hears assertions that the American health care system is “the best in the world.” Instead, he sees widespread injustice, irrationality, malfunctioning, mediocrity, and other failures.\(^2\)


The need for the honoring of an authentic social contract derives from what economists might call “incomplete contracts” in isolated trust- and authority-based transactional relations between individual doctors and their patients. The doctor-patient transactions are “incomplete” contracts because very few if any important parameters and details of complex clinical decision making can be spelled out in perfunctory office consultations. “Informed consent” grossly exaggerates what patients normally understand about their clinical encounters and their consequences, including familial and economic ones. Hence, for trust, compliance, and therefore at least potentially efficacious clinical interactions, patients must believe in the existence of an institutional infrastructure of gatekeepers, guardrails, resources, and regulations constraining and facilitating medical commerce to ensure that clinical decision making is ethical, efficacious, economical, and sensitive to their needs and preferences. Such trusting beliefs are, in reality, largely unfounded, even when the large majority of doctors try to act ethically and professionally.

In light of the health care system’s failures, the existing institutional infrastructure, including the Joint Commission, the private organization that exercises enormous quasi-governmental power in inspecting and accrediting hospitals and other health care institutions. It and other institutions need reform through open and collaborative negotiations among health care providers, lay stakeholders, and biomedical scientists who lack commercial conflicts of interest. Currently, for example, the Joint Commission’s board is controlled by the very interests that it is supposed to police, including the American Hospital Association and the AMA, which handpick the lay public’s few representatives on the board. Resulting reforms need to be complied with by the medical profession in exchange for the privileges, economic and scientific resources, patient deference, and, not least, political power accorded to it.

Recent trends in health care reform that speak of an evolving social contract and of the promise of accelerated medical progress will be adumbrated at the end of this chapter, and explored in detail at the end.

2. Code of Silence

Silence toward the lay world stands in the way of the social contract. Most egregiously, for example, it keeps the public in the dark about the huge numbers of avoidable errors and resulting deaths from medical
This chapter will lay out the origins and evolving character of a code of silence toward the public that was, and is still to a certain but declining extent, imposed on the medical profession by its own norms and organizations. The purpose of the detailed historical discussion in this and following chapters is to illuminate why health care reform will be difficult because of long-standing and deep-seated medical inertia and resistance. The chapter will also point toward discussion in the final chapter about the breakdown of the code, as evidenced by Otis Brawley’s “breaking ranks.”

The early code of the 19th century largely prohibited advertising for patients, and relatedly, criticizing fellow practitioners, even deservedly, in order to attract away their business. It later evolved at the turn of the 20th century into a commitment not to publicly criticize alternative (“irregular”) schools of medicine, especially homeopathy and eclectic (botanical) practices. It was essentially part of a public relations as well as political strategy. The “regular” profession’s competitors enjoyed considerable legitimacy with large swaths of society, so open and fierce denunciations of competing schools and their resulting counterattacks gravely injured its prestige and influence. This was a progressive phase in the code’s evolution, at a time when mainstream organized medicine sought society’s respect in order to gather lay and government support for major public health, drug, and medical education reforms. Starting in the 1920s, however, after the AMA’s hard right turn, a third conservative phase in the evolving code of silence enjoined doctors not to openly challenge the efficaciousness of mainstream medicine’s enormously varying and often useless and dangerous clinical practices at a time when the high and increasing costs of medical care--and relatedly, inadequate coverage of the population--motivated lay social and political forces to question what they were asked to pay for. In other words, the profession’s strategy was to suppress open debate and self-criticism in order to maintain “asymmetric ignorance,” a condition in which the lay world knows very little about how little the medical profession itself actually knows about efficacious and economical medicine. The profession acts as if it to maintain a veil of ignorance that preserves what Paul Starr, in The Social Transformation of American Medicine, calls the profession’s “cultural legitimacy” based on imputed scientific authority, to protect its sovereignty, income, and power. In so doing, the profession has engaged in what Robert Proctor calls “the production of ignorance.”

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3. Airing Dirty Laundry

This chapter will focus on prominent practitioners, scientists, educators, and other leaders in the medical profession who in various times and ways broke the code of silence and sought to alert both profession and public about American medicine’s shortcomings—and suffered unpleasant and costly consequences from colleagues for it. Again, the chapter will point toward a concluding exploration of the current era’s rejection of the code of silence by prominent medical critics, like celebrated Johns Hopkins surgeon Marty Makary, who forcefully calls for greater transparency, and who at the same time garners respect from fellow professionals as well as the lay world.5

A history of reformist advocates of science instead of silence will include prominent New York surgeon Norman Barnesby, author of Medical Chaos and Crime (1910), a scorching indictment of bad but widespread surgical practices, especially in gynecology; Boston surgeon Edward Amory Codman, who suffered for his public criticism of other leading surgeons and the Massachusetts General Hospital for their cavalier disregard for the need for the recording and study of “end results” (outcomes evidence) to reduce deaths and improve outcomes; Chicago’s Arthur Dean Bevan, the Progressive-era AMA leader in medical education reform who instigated the Carnegie Foundation’s famous Flexner report of 1910, which exposed most medical schools in America, most of them for-profit, as “wretched” diploma mills, and, later in the 1920s, was ultimately repudiated by his conservative successors for his public criticism of the widespread therapeutic uses of alcohol—which half of AMA doctors advocated; pioneering Yale nephrologist John P. Peters, Jr., who was smeared as a communist in the AMA journal in the 1950s for calling on government to assist the medical profession in funding, disseminating, and implementing improved medical science and make it widely available through health insurance; Cleveland Clinic surgeon George C. Crile, who made himself persona non grata among organized surgeons for his evidence-based criticisms, first intramurally in the 1950s, and then publicly in the 1970s, of routine radical mastectomies when conservative, and less painful, disfiguring—and remunerative—procedures were called for; John Wennberg, whose career as a medical educator and epidemiologist was temporarily stalled because of his 1973 article in Science exposing the huge, irrational, and wasteful variations in medical practice; and medical journal editors Jerome Kassirer of the New England Journal of Medicine, owned by the Massachusetts Medical Society, and George Lundberg of the Journal of American Medicine, owned by the AMA, both of whom were fired in 1999 for asserting their editorial independence.

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and publishing articles perceived by some as unflattering to the profession and against the grain of its political conservatism.

4. Ignorant Consent

This chapter introduces the idea of adverse selection in competitive medical commerce, which means, crudely, “bad drives out good,” a “race to the bottom,” or “survival of the foulest”--the opposite, in a sense, of “natural selection.” More precisely and fairly conceived, adverse selection means the slide downward into a “low-value equilibrium,” a sluggish slow rise of quality, and the unchecked rise in medical costs. In general, adverse selection is the result of competitive, profit-seeking behavior in information-poor markets, a prime example being medical commerce, where buyers (patients) and their agents (insurance companies) are unable to distinguish good from bad and thus routinely pay for quantity instead of quality, volume instead of value. The profession fosters adverse selection by silencing dissenters, neglecting to request from society the resources and infrastructure needed for generating, disseminating, and implementing evidence-based clinical medicine, and inertia in “de-implementation” through initiatives to eliminate wasteful, low-value care. The chapter will point toward later discussion about reforms that bring more transparency about prices and qualities, and how it, not more market competition, is proving a better guarantee of medical progress.

Historical discussion of adverse selection will touch on the examples of the economically motivated decline of autopsies, a vital source of clinical learning; the continued overuse of dangerous but highly remunerative coronary artery bypass grafting (CABG) in the face of strong evidence against them in many cases; the huge variation in the quantity of blood transfused, for example during CABGs, when transfusion practices not justified by hard evidence can cause serious complications or death while the economically interested collectors and processors, not just surgeons and hospitals, exercise little stewardship of trustingly donated blood; eagerness to continue expensive practices in the absence of clinical studies, as demonstrated by the huge unexplained variations in CABG transfusion rates and other surgical procedures demonstrated to be inefficacious by studies using sham procedures as controls; the

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widespread and often inefficacious off-label prescribing of expensive medications with feeble evidentiary support and much drug industry promotion through questionable, albeit legal channels; and much more.\textsuperscript{10}

5. Drug Money, Hush Money

This chapter will discuss conflicts of interest in transactions between the medical profession, including medical scientists and educators on one side, and the pharmaceutical and medical device industries on the other. The conflicts of interest are pervasive, costly, and even dangerous according to past and current debate in medical ethics and reform circles.\textsuperscript{11} The flow of money from medical commerce to medical practitioners is huge, but mostly non-transparent, minimally disclosed, and sometimes secretive. The chapter will point toward later exploration of recent reforms requiring greater transparency about conflicts of interest, including the inclusion of a Physician Payment Sunshine Act in the Affordable Care Act of 2010.

The conflicts of interest involve medical associations, medical schools, medical journals, the Joint Commission, as well as individual researchers and clinicians. Stark illustrations of the history and current scope of the problem of institutional conflicts of interest will include the AMA’s attempt to block the 1962 Food and Drug Administration legislation requiring new drugs to be subjected to high quality controlled studies of their efficacy as well as safety before marketing, thus resisting societal demand for progress in therapeutic knowledge; the AMA’s silencing and disbanding in 1972 of its independent-minded Council on Drugs under pressure from the drug industry for the council’s efforts to publish compendia on the relative value and risks of highly profitable drugs on the market; the rising commercial conflicts of interests of medical schools and medical specialty societies; major medical journals’ reluctance to investigate contributing authors’ pervasive conflicts of interest; and more. A particularly disturbing case is Purdue Pharma’s role in influencing the Joint Commission’s 2001 influential pain management guidelines and funding its literature, which declared that “there is no evidence that addiction is a significant issue when persons are given opioids for pain control.”\textsuperscript{12}


6. **Squandering Antibiotics**

This chapter will explore how and to what extent the American medical profession’s actions and inactions regarding antibiotics, a vital preventive and therapeutic resource supplied by society for its use, constitute a serious violation of any reasonably conceptualized social contract between medicine and society. The U.S. is one of the top four economically advanced countries in terms of overprescription of antibiotics, which contributes to the development of resistant microbes and generates anticipation of deadly “superbugs” and even a “post-antibiotics era.” The chapter points toward very recent moves to institute better “stewardship” of our declining antimicrobial resources.

The concerns of leading pharmacological scientists and experts on infectious disease like Maxwell Finland, Harry Dowling, and many more about inappropriate use and its deadly consequences grew from the 1940s through the 1960s, yet alarms about an ever-widening gap between best and actual practices had to be sounded by a top health official of the U.S. Department of Health, Education, and Welfare as late as the early 1970s. This “politicization of antibiotics” brought little change, for today at least 30% of oral antibiotics prescribed in physicians’ offices, emergency departments, and hospital-based clinics are still deemed unnecessary. The Centers for Disease Control and Prevention (CDC) estimates that up to 50% of all antibiotics prescribed in acute care hospitals are either unnecessary or inappropriate, and that drug-resistant bacteria cause around 23,000 deaths and 2 million illnesses a year. Between 2000 and 2013, the proportion of bacteria showing resistance to fluoroquinolones, useful for respiratory and urinary tract infections, rose from 0% to 25% respectively. In 2013, Sally Davies, a high ranking UK health official, famously warned that “antimicrobial resistance is a ticking time bomb not only for the UK but also for the world, . . . a threat arguably as important as climate change.”

The American medical profession’s failure to assume early leadership in antibiotics stewardship and regulation at home bears partial responsibility for the growing and now even more rampant overuse in low- and middle-income countries and therefore the growing risk of “superbug” pandemics that can easily travel to this country. Also, the high rate of non-therapeutic use of antibiotics in agriculture including those useful in treating human diseases, for example the recent spraying of Florida orange groves with

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tetracycline—contributes to the looming public health crises. In the U.S., the steady rise in agricultural use did not stop until 2015. While profiting from their sales, the pharmaceutical industry shows relatively little interest in replenishing the stock of antibiotics as they are made obsolete. The insurance industry maintains an arms-length relationship with the medical profession by not trying to regulate its antibiotics use and thereby not encroach on physicians’ fiercely guarded clinical autonomy. In 2014, the performance of managed care health plans in ensuring proper use of antibiotics was stagnant or declining, according to the National Committee for Quality Assurance. Health plans do not pressure hospitals they contract with to institute rigorous antibiotic stewardship programs. Though it publishes relevant research, passes commendable resolutions, and adopts policies calling for better practices, the AMA spends virtually none of its considerable campaign and lobbying resources to pressure politicians to tackle the crisis; its political as opposed to scientific activities concentrate on doctors’ pocketbook issues. Meanwhile, even the reporting of antibiotics usage is not required by law. As of July 2017, only 330 of over 6,000 U.S. hospitals were reporting their antibiotic use to the CDC’s infection tracking system. Thus, the chapter will investigate whether and how the profession’s friendly or at least non-confrontational relations with powerful industries stems from conflicts of interest and constitutes an example of the profession’s stewardship failure.14

7. Alliances Instead of Silences

This chapter will investigate in detail the extent, limited successes, and great handicaps of what might be called a new “Progressive era” in medicine, starting roughly in the 1990s, when internal critics of the profession have felt increasingly free to speak, write, and act in collaboration with lay forces, including the business community, to achieve greater quality, equality, and economy in health care and thus remedy America’s far less than stellar health care performance in international comparisons.15 Even the AMA has shifted slowly in a progressive direction after decades of external criticism and decline. In 2008, the AMA issued its first formal apology for more than a century of policies that excluded African-Americans from organized medicine and the hospital positions, referrals, malpractice insurance, and other privileges and benefits that came with membership in the AMA. For the first time in almost a century, it agreed on the


need for government action to expand access to care with the Affordable Care Act of 2010, which also contained numerous provisions to improve the quality of that care like promotion of “comparative effectiveness research,” reporting of health care outcomes for greater accountability, and easy access to information about individual physicians’ economic ties to medical industries. The era of silence has given way, to some extent, to new transparency, and important medical associations have adopted the idea of developing a new code of professionalism that incorporates self-criticism, transparency about medical outcomes, and openness to collaboration with lay forces to improve the health care system.

For example, in 2002 the American Board of Internal Medicine (ABIMF), promulgated a new professional code, or “Physician Charter,” calling upon the profession to uphold its side of a “social contract” in order to restore trust with patients and the public. Called “Medical Professionalism in the New Millennium,” the charter asserts as its first principles “the primacy of patient welfare” instead of doctors’ economic interests, “patient autonomy” instead of clinicians’ therapeutic autonomy, and “social justice” as something that the medical profession has failed to fight for in the past. To fulfill those principles, the ABIMF enumerates various commitments, including maintaining the public’s and patients’ trust “by managing conflicts of interest” in “personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms.” Patients’ welfare is to be advanced by collective efforts to improve the quality of care, generate better clinical science, and ensure its appropriate use. According to the charter, instead of bioethicist Jay Katz’s “silent world of doctor and patient,” the new medical order should make patients well-informed co-participants in clinical decision making, entailing physician honesty and efforts to “empower” patients to make decisions about which of various possible treatments suit their goals, attitudes toward risk, and their families’ life circumstances. Finally, the charter states that the medical profession must “promote justice in the health care system, including the fair distribution of health care resources” and “work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.”

In 2012, the ABIMF launched a program called “Choosing Wisely,” with the cooperation of over 70 participating medical specialty societies, to publish more than 400 recommendations against overused tests, treatments, and surgeries. In 2015, the Society for Vascular Surgery (SVS) advocated against CABG and other interventionary procedures as a first line of treatment for coronary disease, following up on an earlier 2011 collaboration in a “National Priorities Partnership” of 28 public and private

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16 Michael Millenson, Demanding Medical Excellence: Doctors and Accountability in the Information Age (Chicago: University of Chicago Press, 2000); Swenson, Political Transformations.
organizations convened by the National Quality Forum to examine the overuse of cardiac revascularization. The SVS’s journal called for better research on transfusions during operations to reduce morbidity and mortality associated with excessive use of blood. Also, at least ten different societies warned against transfusions unless strongly indicated, and at least 25 warned against ill-advised prescribing of antibiotics for lack of efficacy fostering antibiotic-resistant bacteria. Breaking the old code of silence, the ABIMF welcomed the publishing of the results by more than 10,000 lay media outlets in addition to hundreds of medical journals. The chapter will examine related developments and collaborations, including, importantly, the recent participation of the Joint Commission, in which the AMA four other major provider organizations collaborate to accredit hospitals and other health care entities, in President Barack Obama’s major initiative to control antibiotics, the 2014 White House Forum on Antibiotic Stewardship. The Forum involved representatives from more than 150 major health care organizations, food companies, retailers, and animal health organizations to deliberate reforms and regulations slow the emergence of antibiotic-resistant bacteria, detect resistant strains, preserve the efficacy of existing antibiotics, and prevent the spread of resistant infections. The result was a presidential Task Force, and, in 2015, an extensive and detailed National Action Plan for Combating Antibiotic-Resistant Bacteria.

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