

**VEBLEN ON MEDICINE: A SOCIOLOGICAL ANALYSIS OF THE  
CULTURAL AND ORGANIZATIONAL DEVELOPMENT  
OF MEDICINE AS A SOCIAL INSTITUTION**

A Dissertation

by

KATHY HILLE

Submitted to the Office of Graduate Studies of  
Texas A&M University  
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

August 2008

Major Subject: Sociology

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**ABSTRACT**

Veblen on Medicine: A Sociological Analysis of the  
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as a Social Institution. (August 2008)

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The focus of this dissertation is to provide a cultural and organizational analysis of the development of medicine as viewed through the theoretical tenets of Thorstein Veblen, one of our most brilliant social and economic theorists. I trace the historical development, examine the current status, and project the future trends of our medical institution. I explore how our current medical system has evolved, both culturally and organizationally, along the same path that Veblen set forth in his social and economic theories of instincts, status emulation, ceremonial-technological dichotomy, and business and market capitalism. I include his thoughts on the development of institutions and the ways in which cultural lag impedes progress.

To accomplish this, I rely heavily on theoretical discussion, interpretative analysis of secondary data, and qualitative analysis of current medical issues. As a result, I discover that the development of medicine as a social institution has followed a predictable course; one that reflects a cultural and organizational dilemma created by the

profit motive, which restricts the implementation of technological advances and negatively impacts the health of our nation.

I find that the ability to view a modern day social institution, such as medicine, through the lens of theories that were at the forefront of social and economic thought at the beginning of the twentieth century, provides us with a unique perspective; the insight to better understand exactly why that development occurred. With that understanding, we are better equipped to alter future development thereby improving structures, processes, policies, and procedures. This research focuses on exposing not only how the institution of medicine evolved but, more importantly, what we can do to improve the delivery of health care and the overall health of our nation's population.

## DEDICATION

To three inspiring individuals whose  
spirits have guided this educational endeavor  
My father Ben McAdams,  
My mentor Derrick Boldt, M. D.  
and  
My husband Arthur John Hille, III

## ACKNOWLEDGEMENTS

I would like to thank my daughter and son. Without my life-altering personal experience of their respective graduations from Northern Arizona University and Baylor University in 1997, I would not have been inspired or motivated to undertake, and subsequently achieve, this educational accomplishment. They both served as the catalyst for me to begin the process and have encouraged and supported me along the way.

I also need to thank my entire family for their cheerleading efforts as I found my way to this point. I made the personal commitment, but it takes much more than that to make something like this happen. Throughout the past nine years they supported me as I moved through the educational process; a non traditional student, with many life experiences, adding formal education to an already full and blessed life.

I am grateful to all the physicians with whom I have been involved over the past forty years of my career in medicine. As a nurse, office manager, practice consultant, and now as CEO of a large medical group, I have ridden their coat-tails to this place where I can now claim the distinction, doctor. Their encouragement and belief in my abilities, ethics, and commitment to medicine have been the source of my strength.

Lastly, I sincerely appreciate the TAMU Sociology staff and faculty. Without Dr. McIntosh and his positive reinforcement and willingness to listen, Dr. Sell and her efforts to continually hold me accountable, Dr. Poston and his patience with a qualitative, applied researcher, and Dr. Mestrovic and his creative, out-of-box style, I could not have arrived at this destination. To all of these individuals, I am extremely thankful.

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## CHAPTER I

### INTRODUCTION

This work reflects an account, albeit one particular account, of how the social institution of medicine has evolved, both organizationally and culturally, over the recent decades. Although Thorstein Veblen did not address the organization of medicine in any of his economic or social theories, nor did he refer to its cultural evolution, the economic and cultural dilemma in which medicine finds itself today is virtually right out of Veblen.

Economically, his perception that money follows a path of profit, one that benefits neither side of the equation; the production side nor the population side, is a direct reflection of how the institution of medicine, with its fragmented organizational structure, has evolved. This one point alone highlights one of Veblen's greatest contributions to economic thought; the dichotomy that industry and business operate at cross purposes (Diggins, 1999).

Culturally, the dichotomy continues. As Veblen's work on higher education in America indicates, there is this ideal of the disinterested scholar searching for the truth in contrast with the demands of business to employ the university to achieve profits and preserve the status quo. He cites this business-culture element as allowing the university to become ever more conservative, inviting intellectual conformity. The same is true in medicine: the medical establishment, looming large as the business authority, is viewing physicians as mere employees. This type of predatory culture, which Veblen defines as lies, force, and fraud, causes men, and women alike, working within the discipline of

medicine, to act as business entrepreneurs, sabotaging the very system they represent. The result is that the patient is a casualty of the profit.

This predatory culture further affects the individual. Veblen felt that society operated as an independent power apart from the individual; a power that permeates the mind of the individual with ideas and concepts that take hold, molding their thoughts so they become oblivious to the underlying processes; those hidden from ordinary forms of consciousness. Over time, these processes develop into social habits becoming an integral part of the individual and their culture. For example, conspicuous behaviors and narcissistic tendencies drive the leisure and vicarious leisure classes to succumb to the medicalization of issues that were previously thought of as normal aspects of aging. Defensive medicine, which is practiced by the majority of physicians today, is a direct result of their unconsciously participating in the sabotage of the very system in which they exist, merely serving to drive up health care costs for everyone.

Then there are the under and uninsured, which by default scramble to work within the system. They crowd our emergency rooms with non-emergencies, enroll in droves into our Medicaid programs, and do whatever they can to obtain medical care, be it through legitimate means or not. Our elderly, covered by the burgeoning Medicare system, are enrolling in private Medicare replacement plans simply to avoid having to pay for a secondary or supplemental insurance designed to cover their 20% patient responsibility; however, due to misleading and confusing advertising by these private business entities, they are unaware that they have actually given up their Medicare benefits to a private, for profit, business. The patient must then navigate an extremely

complex system of referrals, authorizations, and drug formularies. Again, the patient is a casualty of the predatory practices of management, profit.

While this short introduction may rhetorically appear to be more literary than academic, it begs the question as to if academic writings must be like Veblen's, somewhat twisted, difficult and often unpleasant to read, or possibly more like William James, who presents with a much more gracious and relaxed style. My intent is to present both sides of the story, the good and the bad aspects of our medical institution; however, this interpretation and analysis of Veblen's work, as applied to a particular organizational and cultural entity that he failed to address, reflects my world of concrete personal experiences, one that may describe a very different picture than that of others not working within the discipline. It will also include my extensive secondary analysis reflective of the academic research of others, which will serve to temper any bias.

Clare Eby (1994) makes this point in her comparison of Veblen to William James. She states that although there is a remarkable rhetorical contrast, James's critique of academic philosophy closely parallels Veblen's assault on economic theory. James tells us that

the philosophy professor teaches of a universe entirely distinct from the one you left behind you in the street...The world of concrete personal experiences to which the street belongs is multitudinous beyond imagination, tangled, muddy, painful and perplexed. The world to which your philosophy professor introduces you is simple, clean and noble. The contradictions of real life are absent from it. Its architecture is classic...It is a kind of marble temple shining on a hill.

The same is true with medicine. If you witness its cultural and organizational aspects from the outside, your perspective will be very different from those of us that live

it everyday. It will be my task to demonstrate the hidden reality of the cultural and organizational evolution of medicine as a social institution.

## CHAPTER II

### VEBLEN, THE PERSON

After an in-depth integration of invaluable resources on Thorstein Veblen, I have to agree with Rick Tilman's assessment that "no consensus now exists on the value or even the meaning of Veblen's work" (Eby, 1994, p.140).

While some scholars have found his work easy to dismiss because of this lack of ability to achieve consensus, others embrace him for being so mutable. Veblen has been called a unique social analyst because he conveys his ideas in an unconventional rhetoric that seems to defy a separation of the ideas from the words as he uses them (Eby, 1994). Perhaps best said by Wolf Lepenies in his phrase outlining the rise of sociology as being somewhere "between literature and science," Veblen's engagement might be said to be ingeniously combined with his detachment (Lepenies, 1988). Nonetheless, Thorstein Veblen is indisputably an intellectual of many roles.

He has been considered by many as a parliamentary socialist, and a prankish nonconformist, (Riesman, 1953), a ponderous critic of orthodox economics, a theoretician of industrialization and national power, and a moralist who condemned waste and honored work (Diggins, 1999), a great American cultural theorist (Mestrovic, 2003), a great generalist as well as a master satirist (Eby, 1994), the best critic of America that America has produced (Mills, 1953), a premier economic and social thinker, and perhaps our most acerbic social critic (Patsouras, 2004). He had a compelling sympathy for outcasts; immigrants, Jews, workers, farmers, Wobblies, primitive tribes, the small Scandinavian countries, the embattled Soviets, women, and cats (as against dogs) (Riesman, p.139). His

works are so wide ranging and his inconsistencies so well documented, that perhaps that is what encourages everyone to see a different Veblen.

Both John Diggins and the preeminent Veblen biographer, Joseph Dorfman, insist that Veblen is both a detached social scientist and an engaged social critic; however, most studies of his work focus on one facet, to the exclusion of the other. Eby (1994) suggests that one body of Veblen scholarship assesses the validity, methodology, and conclusions of his work to position him as an economist and social theorist, while another group is more interested in his values than his validity and emphasizes his rhetorical analysis as being the key component in his work. I do not believe that it is necessary to choose between the two approaches, because we need them both, to support the dichotomy that is Veblen.

Biographies of Thorstein Veblen are numerous, and the details of his childhood give us valuable insight into the man, who he was and how those circumstances would influence who he became. However, for purposes of this work, I submit a brief biographical summary so as to focus more on what I have come to understand as the underlying principles supporting the inconsistencies and ambiguity in his scholarly work, as they apply to medicine.

Born in Valders, Wisconsin, on July 30, 1857, Veblen grew up in a Norwegian enclave, in what has repeatedly been challenged, as a reasonably well off family. Though somewhat isolated from their Anglo-Saxon neighbors, the Veblens, who numbered fourteen, became successful farmers, even managing to purchase a three hundred acre farm. Thomas and Kari Veblen introduced and emphasized the value of education among their twelve children, and no doubt each of their personalities had a great impact on the

person Veblen was to become. His father was a skilled carpenter and a competent and successful farmer, who Veblen once described as having the finest mind he had ever encountered (Tilman, 1993). He was a hard man, of few words, who possessed a strong work ethic and a keen eye for farming technology, which served to make him a respected power in the Norwegian community (Riesman, 1953). His mother was a softer, imaginative, and altruistic woman, who often served as an amateur doctor in the settlements where they lived (Tilman, 1993; Riesman, 1953).

Veblen received his BA from Carleton College and then attended graduate school at Johns Hopkins University, studying both history and philosophy. He soon left there however, and entered Yale where he graduated in 1884 with a Ph.D. in philosophy. During this time he studied both philosophy and economics and became a master of many languages. Following his graduation, from 1884 to 1891, an academic position eluded him. During this difficult time, he suffered from a psychosomatic illness, and lived both with his parents back at the farm, and also with numerous relatives. According to Joseph Dorfman, Veblen's leading biographer, his failure to secure an academic position was due, in most part, to ethnic and religious prejudices against him. According to Dorfman, "No faculty wanted a 'Norskie,' particularly one suspected of agnostic learnings" (Patsouras, p. 3). During this time frame, Veblen met and married Ellen Rolfe, a past classmate at Carleton College, and returned to academia to pursue post-graduate studies at Cornell University. Finally, in 1892, he secured an assistant professorship at the University of Chicago, only to leave there in 1906 to become an associate professor of economics at Stanford University. He was dismissed from Stanford in 1909 and subsequently found a

position as a lecturer in economics in 1911, at the University of Missouri. The dismissal from Stanford was due to his involvement with other faculty wives, and subsequently the Veblen's divorced in 1912. He soon met and married his second wife, Ann Bradley. All reports suggested a happy marriage until tragedy struck in 1918 when Anne was hospitalized for psychological problems and subsequently died in 1920.

After securing a leave of absence from the University of Missouri in 1918, he served as a statistician at the Food and Drug Administration in Washington, D.C. He fashioned several reports during that time reflecting his stance on the Industrial Workers of the World (IWW) and how the government should allow them to democratically run farm-worker units. When those reports were ignored, he resigned, and his views became even more radical.

During that time, he not only backed the Russian Communist Revolution, but also decided to move to New York, the then radical capital of the United States. He took a position as an associate professor of economics at the New School for Social Research in 1919, which was a sanctuary for radical scholars. He remained there until his retirement in 1926, never having received academic tenure. He died in 1929 just before the great stock market crash.

Personally, Veblen was a minimalist, whose wants were simple, and in some ways he seemingly desired to be underpaid and under ranked in order to maintain his alienation. I feel that it was from this position of alienation that his writings have been the most persuasive. General consensus is that the only major scholarly portrait of Veblen, based on primary sources, is the Dorfman book. Most other accounts on his personality are



derivative in nature. However, Rick Tilman provides us with additional insight. According to Tilman (1993), Jacob Warshaw, a professor of romantic languages at the University of Missouri, recounts a different Veblen. By Warshaw's own account he came to know Veblen very well during his seven year stay in Columbia. Although Warshaw believed that the Dorfman book, which he read, was an accurate account of Veblen's sociology and economics, he indicated that it failed to accurately capture his basic personality (Tilman, 1993). He recalled:

Though I always felt sorry for Veblen as a misunderstood man and a man of sorrows – if he had known of my compassion he would have withered me with a look. I never thought of him as, in his heart, the suave, imperturbable, sphinx-like character who stands out in Dorfman. He struck me rather as a man of spontaneous passions who had found it not the easiest task in the world to keep smiling and to say nothing. The general impression that I get from Dorfman is that Veblen was a quiet, suave, passionless person who broke loose only once or twice in his life and never laughed. Had I not known Veblen pretty well that would have been my picture of him out of Dorfman. My recollections, however, are different. Veblen could get as irritated as the next man and gave signs of his irritation....Under the surface Veblen was highly emotional...He was never the cold-blooded, calculating radical – at least, so it appears to me.....As far as his ability to smile and laugh, I can say that I never found him markedly lacking in it. Few of the readers of Dorfman will realize...that they have been reviewing the life of one of the most learned and most curious of latter-day humanists. By humanist I mean in the case “a lover of learning” and not merely “a lover of polite learning or the humanities” as was true during the Renaissance....It is this insatiable curiosity and this accumulation of all kinds of knowledge that I should call Veblen's humanism...He could be whole-heartedly congenial, as the few persons who visited him in his home can testify. At such times he was at his best, pouring out curious information, throwing off a little malicious gossip which, in view of his seclusiveness, he must have picked miraculously out of the air....behaving like a “regular guy.” An evening with him – when you were fortunate enough to get one – was as good as a French salon or an eighteenth-century London coffee-house.

The different accounts of Veblen's personality are part and parcel, integral to the varying interpretations of his work. By taking the Dorfman account to heart, one may view his trilogy of "instincts" (workmanship, parental bent, and idle curiosity) much differently than if they embraced the thirteen page Warshaw sketch. However, there is no doubt that Veblen possesses a dichotomous soul; an ardent advocate of technology yet making his own furniture out of boxes and burlap sacks, criticizing economists for talking in a way that claimed objectivity while concealing value judgment, yet he claimed nothing and concealed everything. He ridiculed the value of literature and art, but spent the last years of his life translating Icelandic poetry. He was a social philosopher who denounced leisure as wasteful and yet wrote an essay to prove that idleness was the highest state of knowing, and a social scientist who looked forward to modern technology and backward to primitive harmony (Diggins, 1999). These inconsistencies remained a problem for Riesman in that Veblen could praise primitive communal life and workmanship while at the same time welcome industrial technology and that he repeatedly condemned war as barbaric and yet supported America's entry into World War I. Many of us may wonder if these types of inconsistencies ever bothered Veblen. Diggins contends that perhaps Veblen would have merely agreed with Emerson, that a probing mind cannot permit itself to be vexed by the "bugaboo of consistency."

Several anecdotal stories, collected from various sources, are worth mentioning to illustrate his personal idiosyncrasies. It has been reported that a student once asked Veblen "Do you take anything seriously?" Veblen whispered, "Yes, but don't tell anyone" (Diggins, p.33). Veblen penetrated the social world with his writings, but always kept his

own thoughts, on any given subject, a secret. It is said that a friend once picked up a copy of Dimitri Merezhkovsky's *Birth of the Gods* and read Veblen the preface, which ends with the statement that "the living world is the abstract space in which the Christ is being formed." His friend then asked him, as a scholar, what the preface was about. Veblen answered; "It is about four pages and a half" (Dorfman, p.504). Lastly, this recounted story about a New York bookseller, trying to sell a customer a copy of *The Theory of the Leisure Class*, shortly after World War I, provides us with great insight. She recalls:

A man used to appear every six or eight weeks quite regularly, an ascetic, mysterious person with keys to unlock things, I took him to be, and with a gentle air. He wore his hair long and looked Scandinavian....I used to try to interest him in economics...I even once tried to get him to begin with *The Theory of the Leisure Class*. I explained to him what a brilliant port of entry it is to social consciousness. But it became clear that if he was ever to be interested in sociology and economics, he would not be interested in them by me. He listened attentively to all I said and melted like a snow drop through the door. One day he ordered a volume of Latin hymns. "I shall have to take your name because we will order this expressly for you," I told him. "We shall not have an audience for such a book as this again in a long time, I am afraid." My name is Thorstein Veblen," he breathed rather than said. (Jenison, 1923).

This anecdotal account parallels Riesman's statement that Veblen preferred to arrive at places unannounced so that no one would have any expectations of him. By all accounts he was eccentric and unpredictable; for the most part, appearing unkempt, which would serve to support the former perception. In support of his eccentricity, scholars have characterized Veblen as an "alien twice over," a "citizen of nowhere by nature," a "visitor from Mars," an "unacclimated alien," and a "village iconoclast" (Ebbby, 1994, p.156). He appeared to have an almost automatic reaction against anything given. Joseph Dorfman is

the most authoritative of many scholars not only to cite, but to endorse, Veblen's detachment:

The "man from Mars" vantage point....is an especially valuable aid to insight in times of unusually rapid and far-reaching social and economic change....Indeed, it is reasonable to query whether the particular kind of original, fundamental speculations offered us by Veblen would have been possible had he sprung from the mainstream of our society (Dorfman, p.127).

Diggins also supports that Veblen was certainly an idiosyncratic personality and perhaps the most inner-directed character to ever appear in the history of American social science; however, he feels that Riesman's account of Veblen unfairly subjects him to Freudian treatment. Riesman's *Thorstein Veblen; A Critical Interpretation*, stressed childhood determinants, like Veblen's never having exorcised his authoritative father, questioning his masculine prowess as leading him to sympathize with the cause of feminism, declaring that his peasant roots fostered his revulsion toward luxury, and claiming that his fear of success accounts for his inability to rise in the academic world, in part resulting in his perverse work, *The Higher Learning in America*. This one faceted analysis, Diggins feels, serves to minimize the tremendous influence that so many scholarly writers had upon Veblen's intellectual growth, which no doubt fostered the ideas and theories brought forth in his works. These individuals include, but are not limited to, Kant, Hume, Darwin, Mills, Marx, Pierce, Sumner, and Bellamy. Interestingly enough, even though Riesman chose to highlight Veblen's inconsistencies, he also touted his virtues, calling him encyclopedic in his learning and an original theorist who made an extraordinary synthesis from derived materials. He further posits that Veblen's witty and

revealing style reflects his brilliant use of irony as a mode of approach to theoretical questions, leaving us all in his debt for “his way of seeing” (Riesman, 1953, p. 208). According to intellectual history, it is a man’s work, not his life that poses questions for social theory. Veblen may have had his share of neurosis, but not all neurotics have shared his particular insights (Diggins, p.221).

Thorstein Veblen authored ten books and numerous articles, all controversial in nature. The most notable being, *The Theory of the Leisure Class* (1899); *The Theory of Business Enterprise* (1904); *The Instinct of Workmanship and the State of the Industrial Arts* (1915); *The Higher Learning in America* (1916); *The Engineers and the Price System* (1921); and *Absentee Ownership and Business Enterprise in Recent Times* (1923). He was a controversial thinker, always going against the grain; perhaps fueled by the alienation that he experienced throughout his life.

His relevance to this particular work stems, in large, from his theories. I argue, that the social institution of medicine has evolved, both organizationally and culturally along the path of those theories. His theory of status emulation, which is significant in explaining not only ruling-class hegemony but also consumer behavior and corporate predation, his theory of cultural lag, and his contribution to business cycle theory are very pertinent to the development of medicine. His theory of economic growth is closely linked to his thoughts on economic waste in that economic growth cannot be maximized if all output is not serviceable and if efficiency is sacrificed to pecuniary interests. If economic growth stagnates, the economic welfare of the community at large is compromised. The present fragmented system of health care delivery is case in point. As the battle rages

between clinical and organizational specialization and governmental legislation continues to further constrain the activities of physicians, pitting entrepreneurship against predatory corporations, the economic and medical welfare of the community suffers. His theory of social change, which is essentially that technology or machine culture determines the character of a society's culture, speaks volumes to the fact that new technology does not simply bring new laws, new attitudes, or new types of education, but rather it challenges the old. Established institutions are challenged, evoking resistance, and those individuals who have a vested interest in the old order will do everything they can to maintain the old institutions, even when they are no longer in tune with new technological developments; either organizationally or culturally. This process of social change, according to Veblen, occurs when new technology erodes vested interests, overcomes them, and then subsequently begins to reshape habits of thought in accordance to its own needs. This is exactly how medicine has evolved; albeit very slowly, shifting power and authority from physicians to corporations, replacing autonomy with conformity, and decreasing centralization by encouraging specialization. Thus the discipline of medicine suffers from the waste that is brought about by the lack of correspondence and communication between its technology and its institution; as Veblen would say, between industry and business.

Organizationally, his critique of social institutions and their link to corporate 'power centers' highlights his notion of "trained incapacity" and his idea of "conscious withdrawal of efficiency," which substantiates what he refers to as "imbecile institutions," through which we create the conditions of our own confinement. Veblen could see, and articulate, the clash of opposing forces. He posits that our peaceable habits or "instincts"

of productivity and curiosity are in constant conflict with the institutions of waste and futility that we create, thus sabotaging the very systems that we profess to support.

Culturally, his views on narcissism, advertising, and acquired bent, along with his concepts of conspicuous consumption, waste, and leisure are at play in our medical institution where both the leisure class and the vicarious leisure class have joined forces unconsciously sabotaging the medical system, rendering it cumbersome, complicated, and inefficient.

His “instincts” of idle curiosity, parental bent, and workmanship, although in sharp contrast to such traits as predation, exploitation, and ceremonialism, serve to accentuate the dichotomy that is inherent in Veblen’s thought, and it is precisely this dichotomy of thought that has intrigued so many scholars to interpret and analyze his work. For all intent and purposes, one simply cannot read Veblen without actually ‘seeing’ his point regarding profits without products, without realizing that predation has overtaken productivity, and without understanding that the price of those goods has become more valuable than the goods themselves. Industry and business definitely operate at cross purposes, and in the case of medicine, the efficient and effective delivery of health care is compromised, and once again, the patients are a casualty of the profit.

Although Veblen is often criticized for not having developed a systematic theory, at his best he was both a systematic thinker and theorist (Tilman, 1993). It is however, Darwinism that is perhaps the most important consideration in grasping the tenets of Veblen’s theories. He took from Darwin, not the conservative, social approach, that glorifies competition and predation, but the altruistic approach, that studies humanity in its

process of continuous adaptation to the natural environment and subject to the conditions of human existence, as evident by the reality of continuous change. It is from this stance that I propose to argue my point.

The more important question is, who exactly was Thorstein Veblen and how could so many different scholars have seen him in so many different ways? By numerous diverse accounts, we cannot seem to agree on his basic personality traits much less on the interpretations of his work. By integrating the different assessments of Veblen by such preeminent scholars as Dorfman, Riesman, Tilman, Diggins, Patsouras, and Mestrovic, I propose to bring those differing opinions and interpretations into, at the very least, a more cohesive view, so as to establish a clear picture of how the organizational and cultural development of medicine as social institution could be considered a Veblenian parable.

According to Giles Gunn, a professor of English and the Director of the Study of American Cultures, at the University of California, Santa Barbara, “The essential challenge for the American cultural critic is to develop a voice that is attentive, answerable, and, as much as possible, *unassimilable*” (Gunn, 1992). Because of Thorstein Veblen’s rhetorical complexity and the fact that, according to Diggins and Dorfman, he was both a detached social scientist and an engaged social critic, the predicament was, and still is precisely how he remains unassimilable, yet an authoritative voice; one that, despite interpretative differences, has stood the test of time. Veblen has ignited controversy in multiple disciplines, including economics, political science, history, anthropology, and sociology. The sheer number of scholarly responses interpreting and analyzing his theories speaks to the uniqueness and descriptive power of his ideas.



Eby (1994) posits that Veblen established his professional credentials as a scholar and scientist by challenging the existing authority, while simultaneously defending the engagement of satire on the grounds of the detachment of science, while David Riesman (1953) claims that Veblen “used sarcasm which he pretended was science.” However, that is not a sufficient enough statement to address the two sides of Veblen, because we need them both, the scientific and the satirical. It is precisely the dichotomous components of his personality, engagement at the expense of detachment, intellectual recognition at the expense of the rejection of professionalism, and being directive at the expense of disillusionment that make his works all the more intriguing. According to Veblen himself, “Skepticism is the beginning of science.”

It is extremely difficult to distinguish between analysis and interpretation and we should constantly remind ourselves that a fundamental imperative of scientific freedom is that it should be clear to the reader as well as to one’s self exactly at what point the scientific researcher becomes silent and the evaluating person begins to speak (Weber, 1904). It is here, where those two axes of social theory join, that Veblen’s work exists. Whether he fooled even himself with his objective stance is mere supposition, but I would assert that he was keenly aware that his interpretations were as relative as those he discredited and that because of his fascination with what lies outside the margins of the accepted social order, he knowingly had a vested interest in his detachment. Aptly put forth by Riesman, only a character-conditioned refusal to become tempted by practical life tasks could sustain the sort of detachment from culture that was Thorstein Veblen.

## CHAPTER III

### LITERATURE REVIEW

What threatens us today is “not the end of the world, not the elimination of all life in a single Cataclysmic mushroom cloud, but rather a gradual, unending, cumulative deterioration in the name of progress” (Morris, 1998, p.106).

I would argue that this comment, by David Morris in his book *Illness and Culture in the Postmodern Age*, perhaps expresses the same sentiment that Thorstein Veblen may have had in regards to the development of medicine as a social institution had he addressed the rise of medical authority and the shaping of our medical system from its inception to the present day.

Therefore, a closer look at the social transformation of medicine in America sets the stage for the analysis and interpretation of that evolution through the principles and tenets set forth by Thorstein Veblen.

#### **Medicine Today**

American health care is the most expensive in the world, with the United States spending almost twice as much per capita on health care than any other country. As of 2006, health care spending, as a percentage of GDP, is 16% in the United States as compared to 11.1% in Germany, 7.9% in Japan, and 7.7% in the UK (Health Affairs, 2006). Our costs have increased dramatically as health insurance premiums have increased 87% since 2000, with the average annual premium for family health coverage at a staggering \$11,480.

Health care costs now represent 33% of employee benefits, compared to 32% for all other benefits combined; sick leave, vacation time, and holiday pay. These costs are continuing to rise with another 6% increase predicted for 2007. This means that the average family premium exceeds the gross income of a full-time minimum wage worker (Towers Perrin, 2007).

Not only are the health care costs shocking, but in spite of our medically advanced technology and knowledge, we are not a healthy nation. From a public health perspective, our health care system is mediocre, at best. The United States, which is one of the most industrialized nations in the world, presently ranks 42<sup>nd</sup> in life expectancy at 77.9 years. We have one of the highest obesity rates, with one third of our population obese and two-thirds overweight. Our rates of diabetes and heart disease are the highest in the world. Forty countries in the world, including Cuba and Taiwan, have lower infant mortality rates (National Center of Health Statistics, 2006).

Not only are the costs shocking and the care mediocre, but the system is inefficient. Our commercial health plans take 12% to 20% of our health care premiums in administrative costs and profit. Our current Medicare system takes 5% of our health care dollar in operational costs. Costs for all health care providers have increased because the multiplicity of payment methodologies has greatly increased the administrative costs. As an example, in the early 1980s, non-physician staff (non-clinical) numbered two individuals per physician. Now that same non-clinical, administrative staff numbers four to five individuals per physician. In addition, 15.8% of our population is uninsured because of high costs and limited access. These inefficiencies come with a price, a very

high price. The cost of the uninsured to medical providers alone was \$73.3 billion in 2004. Forty million of that was accounted for as uncompensated care (bad debt and charity care), while \$33.3 million was received in the form of out-of-pocket payments from the uninsured (Kaiser Family Foundation, 2006).

Studies indicate that conservative methods of treatment are as successful as aggressive treatment, yet our reimbursement systems rewards the delivery of procedures and drugs, discouraging primary, preventative, and wellness care. Our reimbursement system gives hospitals over 35% of the health care dollar and physicians about 24%, yet our health care laws will not allow hospitals to share their dollars by paying physicians for quality and efficiency; a process we call gain-sharing. While policymakers dislike the overuse of procedures and bemoan the lack of primary care, they still authorize higher reimbursement for procedures. At the same time, costs are then shifted to patients already overburdened with increased premium costs, by increasing co-pays and coinsurance amounts, thereby ensuring that patients won't go to the doctor until they are sick. Lastly, drug advertising is a clear contributor to rising health care costs, but yet we don't restrict it.

All of these issues have an impact on the overall health of our population. In 2006, 38% of our population chose not to fill prescriptions, 32% didn't see a physician when a medical condition existed, and over 30% skipped follow-up exams and recommended testing (Towers Perrin, 2007).

Another reason for added costs and inefficiencies relates to government regulation. According to Flood (1995), there are a myriad of self-interested and contradictory roles in which various government and regulatory agencies participate and we need to better assess

the extent to which they represent a limited perspective in the evaluation and promotion of efficiency and quality of care. The United States has an extremely complicated regulatory scheme imaginable for health care. Federal laws, the violation of which result in criminal charges, include fraudulent Medicare and Medicaid reimbursement and billing, Stark law and regulations, anti-kickback law and regulations, antitrust laws, and assorted tax laws and regulations. At the state levels, there are commercial insurance regulations, licensing of facilities and professionals, state fraud and abuse laws, corporate restrictions, consumer fraud laws, and state privacy laws. The result of this is a mass exodus of physicians from health insurance products including Medicare, Medicaid, and commercial plans, the creation of retail and concierge medicine, self-pay practices, and non-insurance practices. Practitioners are now doing everything they can to “work the system” instead of working with the system.

High costs, mediocre health care, and inefficient health practices leave us with the need to reform our current health care system. These issues are current topics of debate, not only within the institution of medicine and the medical community, but also in our economic and political arenas. The future of health care reform will be addressed later in this work; however, understanding the social origin of medicine and then analyzing its cultural and organizational development through the interpretation of the social and economic theories of Thorstein Veblen, is the focus of this work.

## **Social Origins of Medicine**

Medicine relates to an art as well as to pure science, and the practice of medicine concerns the interests of individuals. In fact, the whole character of a society may be conditioned by the nature of the diseases common to it; for just as medicine influences a society, so society influences medicine (Shryock, 1979). For this reason the social factors as well as scientific advances should receive consideration. According to Paul Star (1982) the history of medicine has been written as an epic of progress, but it is also a tale of social and economic conflict between the rise of power and authority, the development of new markets, and the evolution of experience. In America, no one group has held so dominant a position as the medical profession. From its meager beginnings when independent physicians ministered to the medical needs of patients under a simple fee-for-service arrangement, in cooperation with non-profit, independent, community hospitals to today's complex multi-specialty physician groups who address the medical needs of patients under a complicated, regulatory laden managed care arrangement, in direct competition with large, for profit medical complexes owned by large corporations, the medical profession has managed to turn its authority into social privilege, economic power, and political influence (Mick, 2003).

How the American medical profession has risen to this position of cultural authority and also managed to shape the institutional structure of medical care in this country are pertinent to this discussion. As social structure is the outcome of historical processes, we have to look at the development of medicine to understand how we find

ourselves situated today (Star, 1982). We would need to understand the ways in which people thought and acted under certain conditions, for it was their “habits of thought” that brought this structure into existence.

*Prior to the 1920s*

Prior to the 1920s, the medical profession was generally weak, divided, and unable to control the physician’s entry into practice or to raise the standards of medical education. It certainly did not provide the security of status or the levels of income that are present today; however, it was during this time that medical authority began to establish its foothold. This is important, as authority, in the classical sense, signifies the possession of some status or claim that compels trust or obedience (Star, 1982; Lukes, 1978). Although authority signifies a potential to use force or persuasion, the use of force signifies the failure of authority (Arendt, 1961). So we should assume that authority calls for voluntary obedience, but holds in reserve the power to enforce it. This growing sense of medical authority incorporated two sources of control; legitimacy and dependence, which over time has served to foster its acceptance. According to Steven Lukes, the acceptance of authority signifies “a surrender of private judgment” and as physicians gained more prominence, thus commanding more authority it made it unnecessary for them to elaborate on the reasons for their medical decisions, as well as eliminated any presumed use of force. This, according to Paul Star, is authority’s economic value. For when patients seek medical advice, authority may well be the shortcut to where reason is presumed to lead, thus creating the cultural authority needed to establish dominance. This cultural authority,

fortified by the dependent emotional condition of patients, launched the construction of reality; a reality through which the definitions of fact and value became the cornerstone for the development of the medical establishment.

### *1920s to Early 1960s*

From the 1920s to the early 1960s this cultural authority became even more dominant. By shaping patients' understanding of their own experience, physicians created the conditions under which their advice seemed appropriate (Star, 1982, Mick, 2003, Shryock, 1979). Professional medical associations exercised primary control during this era (Scott, et al, 200). They were backed by public agencies and exercised legitimate control over the central bodies and activities within the professional sector. During these four to five decades, the medical profession was comparably stable, asserting its new found dominance while simultaneously reproducing it from one generation to the next through the creation of an institutionalized system of licensing and education. Physicians were also able to establish organizational structures that preserved their dominance and autonomy. This dependence on professional authority, which by now had fostered paternalistic behaviors among physicians, increased even more with the rise of hospitals where clinical personnel, subordinate to the physician, replaced the family as the patient's caregiver. They not only administered treatment in the physician's absence, but they kept a watchful eye, maintained records, and reinforced the message that physicians' orders are to be followed. They became vicarious agents for physicians, thereby spreading both social and cultural authority. Social authority in that, as social agents, they directed patient care, gave



out commands, and carried out physician orders, and cultural authority in that they constructed the patients' reality through experience. All of this serving to further embed professional authority into what was rapidly becoming a monopolistic institution, owned, operated, and run by the powerful medical establishment; the physician elites. It was during this period that their professional authority was converted into high income, they attained limitless levels of autonomy, and they achieved economic power.

With the emergence of hospitals, a market for medical services was created. These hospitals began their operations as independent, locally embedded organizations. Then, loose associations of hospitals formed to pursue limited, mutual goals, but primarily they remained individual services units, freestanding and independent (Scott, et al, 2000). At first this economic market was inseparable from the physicians' professional authority (Star, 1982; Shryock, 1979), but this arrangement changed in the 1960s.

#### *1960s to 1990s*

From the mid-1960s to the 1990s, the medical profession underwent radical changes, both culturally and organizationally. With the emergence of federal involvement, via funding and imposed regulations, the governance structure of the professional association gave way to the state (Scott, et al, 2000). The systems were now complex, involved, and intricately interrelated. Patients were concerned and too often confused; physicians, nurses and other providers were overwhelmed and often angry; politicians were uncertain; managers and health care administrators were stressed and criticized; and investors and financial analysts were seeking to learn how to make a profit of illness

(Mick, 2003, Alford, 1972, and Star, 1982). Having watched for many years the spectacle of a system that displayed “dynamics without change” many were having a hard time understanding the characteristics, causes, and consequences of this institutional evolution.

During this time multi-hospital systems emerged and grew rapidly (Scott, et al, 2000). Affiliations were increasingly forged between hospital organizations, creating both for-profit and nonprofit systems. The rise in these bureaucratic organizations posed several threats to the medical profession. One such concern was that these organizations might employ physicians who would render medical care. If so, they would no doubt provide competition to independent physicians who had thus far gone unchallenged. Another concern was that these organizations, that provided financing for medical care, like hospitals and insurance companies, might subject physicians to unfavorable economic terms of exchange and also find ways to circumvent their autonomy by adding layers of bureaucratic administration, thereby limiting their decision-making. The physicians fought these advances, and for the most part they were successful early on, escaping the constraints of capitalism while becoming small capitalists themselves. I would argue that this is where medicine became a “run away” train. There is little doubt that leaving physicians outside of the structures of these up and coming organizations increased the costs of medical care (Star, 1982, Mick, 2003, Scott, 1981). The complexities of monitoring physicians were enormous. As independent entrepreneurs, physicians were not sensitive to corporate issues like conserving resources, and hospitals and insurance companies had no other choice than to pass through the higher costs produced by professional autonomy to patients. Physicians still maintained economic power because it

was their professional authority that controlled the purchasing power of patients. From the standpoint of a health insurance company or a hospital, having the authority to prescribe meant having the power to destroy (Starr, 1982).

However, Perrow (1991) posits that large organizations increasingly “absorb” society, internalizing functions that might be better performed by communities and civic society. With the increasing power of these organizations, independent physicians saw their autonomy and cultural authority slipping away, but not everyone saw this as a problem.

Hospital administrators, CEOs of insurance companies, and other corporate executives, who saw and developed a market of ancillary businesses that would service the medical industry, like pharmaceuticals and hospital equipment companies, were gaining strength. We should remember that sociologically these organizations should also be referred to as actors in their own right; as collective actors who take actions, utilize resources, enter into contracts, and own property. And while organizations can achieve goals that are quite beyond the reach of any individual, they do conceal far reaching effects; effects that are often unanticipated, unrecognized, and unacknowledged. An example of this might best be explained by Ivan Illich, when he said:

Although we seek “health” when we visit the clinic or the hospital, what we get is “medical care.” Clients are encouraged to view these outputs as synonymous, although there may be no relation between them. In some cases, the relations can even be negative; more care can result in poorer health (Illich, 1976).

So while corporations took their place in medicine along side physicians, medical costs were on the rise, beyond what many American families could afford. It was felt that some agency was needed in order to spread the cost, and that it would have to be a third party, exactly what physicians feared. The struggle of the profession to maintain its autonomy became a campaign of resistance. To continue to escape the corporation and the state meant preserving a system that was at war with itself (Star, 1972, Illich, 1976, Mick, 2003).

That third party came forth in the form of the Medicare and Medicaid initiatives that Congress passed in 1965. These programs covered the hospital costs and physician fees for the elderly and provided assistance to the states for medical care for the poor. Initially physicians said they would boycott, but cooler heads in the AMA prevailed and the profession not only accepted Medicare, but discovered it was a bonanza. Even Medicare's implementation of DRGs (diagnostic related groups), which are codes used to curb health care costs by reducing the amount of money paid for specific illness groups thereby subjecting hospitals and physicians alike to cost containment, proved to be less effective than hoped in containing medical costs. But they did, however, manage to institute some standards regarding medical service billing that have subsequently been followed by commercial insurance carriers alike.

Costs continued to rise with the increased usage of health care services by the elderly and the poor. According to health care policy analysts, and elite members of the AMA, the answer appeared to be that instead of a public system of health care having to meet financial costs, the private sector should address the crisis. Therefore, it was

presumed that managed care might be the vehicle through which medical costs could be contained. Managed care is an insurance product offered by private organizations that not only perform the insurance functions of pooling risks, but also actively participate in the management of patient care, assuming roles formerly performed by physician providers and governance units (Scott, et al, 2000). The “arm-length” relationships between these financial intermediaries and physicians have evolved into somewhat closer, yet some would say, more intrusive arrangements. While the goal of managed care is to provide health care in an as cost-efficient manner as possible, the fiscal management of health care dollars under their control is a source of contention with physicians who feel that their clinical autonomy has been jeopardized. Being told who they can see by having to obtain time consuming and complicated referrals and authorizations, how they can diagnose by restricting the approval of certain diagnostic tests and methods of clinical deduction, and how they can treat by strict adherence to drug formularies and approved treatment outlines, the physicians feel that their clinical authority is compromised.

However, these managed care arrangements, the HMO’s (Health Maintenance Organizations), independent practice associations, and commercial health insurances, through competing for subscribers (patients) and negotiating fixed rate reimbursement contracts with physicians and facilities, have proved to be the panacea. Although these products have not fixed the health care industry’s problems, the profession itself is no longer steadfastly opposed to the growth of corporate medicine. Overall, the physicians’ commitment to solo practice is eroding and large single specialty and multi-specialty group practices are becoming the norm. Physicians still hold authority and strategic position, but

it is not as strong as it once was. Specialization has fragmented physician unity and reform is taking its toll. Even the AMA (“American Medical Association”), a once elite establishment, is no longer devoted to solo practice nor opposes the corporate practice of medicine. Dr. Sammons of the AMA stated that “there is no way we could be” because a high proportion of the AMA members are now involved in corporate practice (AMA, 1982). Some twenty six percent of AMA members have contractual relationships with hospitals; many are on salary; and about half of physicians that are in private practice have set up professional corporations to take advantage of special tax sheltering provisions (Star, 1982, Mick, 2003).

#### *1990s to Present*

From the 1990s until today, we find that health care spending has still increased rapidly, despite the presence of managed care. By 1995, managed care had become the dominate form of health insurance and enrolled seventy-three percent of all Americans who were covered by employer based health benefits (Mick, 2003; Jenson, 1997). Hospital downsizing and consolidation has occurred frequently, physician group merger and subsequent vertical integration of ancillary services has increased, and urgent care centers, surgi-centers, and ambulatory care centers are operating successfully in medical markets across the nation (Mick, 2003; Heffler, 2001). Huge integrated health systems that virtually connect multiple types of providers together with insurance functions and medical group participants dominate the medical landscape (Scott, et al, 2000). Additionally, the governance structure has again repositioned itself, having first been that of professional

associations, then giving way to the state, and now emerging as a market centered framework (Scott, et al, 2000). These corporate options to health care have become accepted by policy analysts, health care administrators, and physicians as efficient and effective alternatives to the more expensive hospital settings. This rise of corporate culture in medical care is one of the most significant consequences of the changing structure of medicine. People that talked of health care planning in the 1970s now talk about health care marketing. We all see the outgrowth of a marketing mentality in health care. Whereas the organizational culture of medicine used to be dominated by the ideals of professionalism, it is now seemingly about the economic market. The “health center” of one era is now the “profit center” of the next (Star, 1983, p. 448). Additionally, we should note the significant parallel in the bureaucratization of health care during the past decade as witnessed by the growth of large integrated health systems alongside the concurrent “deprofessionalization” of medicine. The separation of the knowledge elite, exerting technical and cognitive power, from the administrative elite, wielding economic and organizational power, has whittled away at the core of our medical institution, the physician (Hafferty, et al, 1995; Flood, et al, 1995).

However, it is important to recognize that no organizational field is isolated from the wider social, cultural, and economic conditions in which it exists and, having said that, a trend is not necessarily fate. Simply put, further change is inevitable and the future of our health care system is uncertain.

### **Veblen's Theoretical Orientation**

Having briefly outlined the development of medicine, it is now necessary to identify those theories attributable to Veblen that, I argue, trace that development. According to Diggins (1999), Veblen never bothered to explain what he meant by the term “theory,” even when he used it in the title of his most famous book. However, during the time of his work, society and social consciousness had become problematic. Society was perceived to be an independent power set apart from the individual; a power which imposed its hold on the individual through the mind. By molding a person’s thoughts and ideas through socializing methods, the underlying, more complicated and unconscious processes remained hidden. It was those unconscious processes that posed an issue for Veblen; processes that were responsible for the ills of society. So theory, for Veblen, enables an individual to penetrate those processes; to discover, identify, and accurately interpret those issues for which changes need to be made for the betterment of society. Through “idle curiosity” and detachment, not social involvement and political activism, someone could possibly change the future.

Veblen was not engaged in amassing facts about things, but in evolving theories about ideas; however, he often attacked theories themselves for having somewhat of a limitation (Sowell, 1967). He thought that theories could often confine men’s efforts in solving problems that were within their scope. He proceeded intuitively with little regard to making his theories empirically testable, but it was not that he did not have the facts, just that he did not use the facts in that way. He simply judged others’ ideas in terms of their



plausibility, did they make sense and did they reflect the historical, evolutionary, and cultural context in which they existed?

*Theory of “Instincts”*

For Veblen, his trilogy of “instincts,” which have been widely identified as the “*instinct*” of *workmanship*, *parental bent*, and *idle curiosity*, is a source of moral absolutes (Eby, 1994; Riesman, 1953; Tilman, 1993; & Diggins, 1999). What they have in common, according to Riesman, is a turning outward from the individual to nature or society, a merging of the individual through work, observation, or solicitude in the processes that surround him (1953, p.56).

In general these three “instincts” demonstrate their differences from such counterproductive traits as predation, exploitation and ceremonialism in numerous ways and through various situations. Veblen’s use of these concepts appears consistently throughout his work. They are incorporated, in subtle ways, within his different theories, and their application to the development of medicine is no exception.

According to Veblen in his book entitled, *The Higher Learning in America*, idle curiosity is the knowledge of things sought apart from any ulterior use of the knowledge so gained (1918, p.148). It is the impulse to gather knowledge for its own sake. It is a sort of playful inquiry, which forbids a functional role; an instinct that makes us want to know things; things that will eventually be turned to useful ends, so to restrain it would be to impede technological and scientific progress (Riesman, 1953; Eby, 1994). For under the guidance of idle curiosity, there is a continued advance toward a more comprehensive

system of knowledge, and with this advancement comes a closer observation and a more detailed analysis of facts (Veblen, 1906, p. 592). Eby (1994) posits that idle curiosity is essential to Veblen's intellectual authority because its "curious" nature permits skepticism while its "idle" quality eludes responsibility, and while she doesn't agree with Riesman, who charges Veblen with celebrating idle curiosity to counter charges of laziness, she does argue that it has allowed him to deny making proposals for change on the grounds that he is pursuing a merely "speculative" inquiry.

The "instinct" of workmanship, an assumed human propensity for activity tailored to the efficient achievement of a goal, outlines the imperatives of social equality that are held by the industrial labor force (Riesman, 1953; Tilman, 1972). It is that force which motivates us to make things. For Veblen, man's great advantage over other species in the struggle for survival is his superior facility in turning the forces of the environment to account, his proclivity for turning the material means of life to purpose, and his proclivity to achievement. In his economic life, man is an agent, not an absorbent; an active agent seeking the accomplishment of some concrete, objective, impersonal end (1898, p. 189). In his work entitled, *The Instinct of Workmanship and the Irsomeness of Labor*, there seems to be an inconsistency or contradiction, which is not altogether a rarity for Veblen, in that he argues that man has an aversion to labor, but yet an instinct of workmanship. However, Veblen explains this ambiguity quite well in that the aversion to labor is a conventional aversion only, and that when a man is not "harassed with the strain of overwork" his common sense speaks to his instinct for purpose. "They (men) like to see others spend their life to some purpose, and they like to reflect that their own life is of

some use” (1898, p.189). He even argues that ostensibly purposeless leisure had come to be disapproved of by a large portion of the leisure class whose common origins put them in conflict with the tradition of leisure with dignity. Because of this, the notion of the “instinct” of workmanship, which Veblen posits is also inherent in the leisure class, albeit subtly, is changed somewhat, in form rather than substance. Polite observances, social duties of a ceremonial nature, and the creation of many organizations, with some specious object of amelioration embodied in their style and title are created to confer purpose to their leisure class life (1994, p. 59).

Lastly, parental bent, which is said to represent a general solicitude, or excessive care and attention, not only for one’s young, but for the future of mankind and the general welfare of the race at large, guides man toward more efficient and productive activities in the interest of posterity, thus reinforcing the sense of workmanship. So closely connected are these two “instincts” that Veblen suggests that workmanship could be regarded as the means by which the ends of parental bent are realized (Riesman, 1953; Diggins, 1999).

Although Veblen’s theory of “instincts” puts a grimace on the face of many scholars, his belief that man’s natural gifts and instinctual nature have not completely been obliterated by the institutionalized creature that he has become, leaves some hope for mankind. Perhaps our “instincts” are not smothered, but remain in tact, just somewhat stretched and distended by the process of growth and progress.

*Theory of Status Emulation*

More recently, Veblen's thoughts on status emulation, which serve as the basis for his book on *The Theory of the Leisure Class*, have been well received by and compared to those of other modern social theorists. Diggins (1999) felt as though Veblen's thoughts on status emulation speak right to the heart of the problem of power in modern America. Veblen realized that in a democratic society prestige or social status is as important, if not more so, than raw power itself, and it was through invidious behaviors, social competitiveness, and emulative consumption that the middle class was created and the leisure class was able to preserve their highly distinctive place in society (Tilman 1984; Riesman, 1953; Sowell, 1967). The emergence of the leisure class coincided with the beginning of ownership, and the wealth that resulted from this ownership conferred honor, which is an invidious distinction (Veblen, 1994, p. 17). It also conferred power, power that afforded individuals a motive for accumulation which then fostered a predatory stage where self-seeking behavior became the dominant note that shaped the scheme of life (1994, p. 21).

He also argued that those social classes that were most able to conspicuously consume, waste, and avoid useful labor were the most likely to command social honor and influence by virtue of deference from the other classes, leading Veblen to believe that status emulation, rather than class analysis, was often a better key to understanding the psychology of our class system (Tilman & Simich, 1984; Tilman, 1993; Eby, 1994).

Because social classes emulate the social status or position above them, a psychological condition of pecuniary canons of taste – the habit of judging people and

things according to their price tags – developed (Sowell, 1967). This ‘psychology of the classes’ fostered cohesiveness in the upper levels of power where competition with interest groups at the middle and the fragmented masses at the bottom only served to perpetuate emulatory values.

According to Mestrovic, the result of status emulation is a culture of narcissism, where one side of a person is obsessed with status, displaying envy, self-absorption, and a lack of empathy, while the other side feels worthless and therefore seeks admiration and acknowledgement from others (2003, p. 3). This type of self interest is possible only when it accompanies predatory life, and predatory life, according to Veblen, is possible only after a culture has developed so far as to have a surplus over what is required for mere sustenance (Veblen, 1998, p. 194). As these cultural forces emerge, the likes of which have transformed most social institutions into business enterprises, they create institutional forces that psychologically shape, reinforce, and perpetuate this concept of status emulation.

This concept has proved so powerful that the likes of Mill’s power-elite, Mumford’s mega-machine thesis, and Domhoff’s thoughts on the contemporary elite, capitalists whose wealth/power/prestige have developed through social indicators, are all derivative of Veblen’s leisure class (Patsouras, 2004). For Veblen, with the exception of the instinct of self-preservation, the propensity for emulation is probably the strongest and most alert and persistent of the economic motives (1994, p. 68). This modern American phenomenon, this panoply of power, exists because of emulatory values.

*Ceremonial-Technological Dichotomy*

Veblen's most celebrated concept, the business-industry dichotomy, incorporates both his status emulation theory as well as his theory of market capitalism. It focuses on the differences between business and industrial pursuits (Tilman, 1984). Veblen argues that the adjustments of industry take place through the mediation of pecuniary transactions, and that these transactions take place at the hands of business men, who use them to achieve business ends, not industrial ends (Veblen, 1904, p. 19). These business men, or capitalists, undertake production only if they feel confident that they will receive a financial remuneration higher than the amount of money spent during the production process; thereby choosing a low production/high-price model; one that will generate the most profit. This is in direct conflict with the technicians/engineers instinct of workmanship; the production of useful goods. Because of this, a fundamental conflict exists between the making of goods and the making of money, both of which stem from human "instincts"; however, it is business that directs industry (Tufts, 1904).

Because the making of money has overtaken the making of goods, business and industry often operate at cross purposes (Diggins, 1999; Sowell, 1967; Passos, 1936). While business occupations involve personal competition and produce invidious concepts such as merit and status, industrial occupations deal with more impersonal laws of science and tend to produce narrower ideas of cause and effect, which the business class considers irrelevant (Sowell, 1967); irrelevant because these two entities, business and industry, are operated by very different animals who possess very different "instincts." They are the businessmen, or Captains of Industry and absentee owners who, Veblen argues, possess

bad “instincts” such as vested or self interests, exploitative tendencies, and predation, which lead to ceremonial and predatory behaviors, like force and fraud and then the technicians, engineers, and industrialists who possess good “instincts” such as workmanship, parental bent, and idle curiosity, which lead to instrumental behaviors like problem-solving, invention, and innovation. Because institutions are, according to Veblen, habits of thought, bad “instincts” create vested institutions such as businesses; ones that are run by businessmen not terribly different from the medieval robber barons because they use force, cunning, and competitive skills to make money from others, living off the spoils of conquests rather than producing things themselves. To promote their vested interests, they block progress wishing to maintain the status quo, their profit. To do this they often sabotage the system, which is often sanctioned by law and public conscience, through industrial layoffs and financial maneuvers of restricting and delaying production, often dispersing resources rather than producing commodities that would contribute to the generic ends of life (Diggins, 1999; Tilman, 1993).

Veblen is often compared to his contemporary Frederick Taylor and his concept of “scientific management.” They both shared their disgust with the waste and confusion of industrial system, while embracing a system of increased productivity, guided by science and lead by engineers, rather than profit, lead by businessmen and financiers, that would mean social progress for the masses (Diggins, 1999; Patsouras, 2003; Riesman, 1953). For Veblen, this ceremonial-technological dichotomy clearly demonstrated that industrial sufficiency had been sacrificed for business prosperity; however, there was a larger social problem; one that existed because the reality was, and still is today, that the growth of

business enterprise rests on technology as its foundation. In the long run, business principles cannot win, since an inhibition or mutilation of the machine system would gradually push business enterprise to the wall and a free growth of the machine system would cause business principles to fall into abeyance (Veblen, 1904).

### *Institutions and Theory of Cultural Lag*

Richard Shryock (1979) argues that there is a natural tendency to say that scientific problems have been solved, or that they are in the process of being solved, and that the obligation now becomes to make the knowledge more widely available. He further posits that in medicine, technical advances seem to have outstripped social adjustment, and that the liberal critics of American medicine are inclined to view it as more technically advanced yet more socially backward than almost any other country. This example of cultural lag exemplifies Veblen's thoughts on the development of social institutions.

In *The Theory of the Leisure Class*, Veblen suitably argued that:

The situation of today shapes the institutions of tomorrow through a selective, coercive process, by acting upon men's habitual view of things, and so altering or fortifying a point of view or a mental attitude handed down from the past. The institutions – that is to say habits of thought – under the guidance of which men live are in this way received from an earlier time, more or less remotely earlier, but in any event they have been elaborated in and received from the past. Institutions are products of the past process are adapted to past circumstances, and are therefore never in full accord with the requirements of the present (pp.118-119).

For Veblen, institutions were patterns of ideas, not organizational entities, and his concern was to analyze where the ideas came from, not to describe the mechanics of the



institution (Sowell, 1967). Since he argued that modern institutions rested on predatory business principles and must make money in order to pursue their humanitarian objectives, he felt that they often create the needs they serve through exploitation and competition (Mestrovic, 2003; Riesman, 1953).

He had grave reservations as to the progressive nature of change and whether or not society could produce a change at all because he felt that the engineering class was too integrated into business system to constitute a negation of it and that underlying populations would have to continue to put up with imbecile institutions because they would absorb its cultural ethic of individualism and materialism (Diggins, 1999; Sowell, 1967).

Veblen was also insightful regarding the paradox of labor – the idea that labor is the source of wealth, yet the laborer is ignored, while the businessmen not only take the credit, but also reap the reward, profit at the expense of the masses (Machalek, 1983). The natural progression of vested interests and ideas being linked together to protect and preserve the status quo provides the segue to his thoughts regarding cultural lag. He felt that institutions lag because while some groups would win, others would lose by their success or failure to adapt. So cultural lag is a power phenomenon in which conflicting strata play a zero-sum game rather than participate in adaptive processes where everyone would benefit (Tilman, 1984). These “imbecile” institutions, as Veblen referred to them, are inhibitory and backward looking, always archaic in some degree, while science and technology are dynamic and oriented to change (Eby, 1994; Tilman, 1993). Interestingly enough, the more removed they are from daily life, the more out of date they are bound to be. And while we welcome technological advance, we resist social innovation because it is

the arbitrary authority that emanates from these institutions that manifests this cultural lag (Diggins, 1999; Tilman, 1972).

Being somewhat pessimistic regarding our ability to escape the cultural confinement of these institutions, Veblen posits that

.....history records more frequent and more spectacular instances of the triumph of imbecile institutions over life and culture than of peoples who have by force of instinctive insight saved themselves alive out of a desperately precarious institutional situation (Hayes, p. 706).

### *Theory of Business or Market Capitalism*

At a time when Veblen's contemporaries still thought in local and traditional terms, he was aware of one fundamental truth: the inescapable interdependence of a modern economy (Riesman, 1953, p.91). Veblen argued that the businessman, especially the businessman of wide and authoritative discretion, had become the controlling force in industry because through the mechanism of investments and markets, he controlled business processes, thereby setting the pace and determining the direction of movement for the rest (1904, p. 8). He also felt that the economy was certainly more than the 'market' and should be studied as such, holistically and historically, taking into account economic, political, social, and cultural dimensions. The separation of business or profit from industry or production had contributed to economic instability, because of excessive capitalism and credit inflation, which controls the business cycles (Bascoy, 2003; Tilman, 1993). He anticipated that the growth of monopolies and wasteful government expenditures might check the instability; however, it did not. His view that business was

strangling industry was prophetic in the sense that he saw that economically we had become one world unable to return to mercantilist autocracy (Bascoy, 2003; Riesman, 1953).

He characterized modern business as a system of pecuniary rivalry and contention whose aim and usual outcome was an accumulation of wealth (Veblen, 1904). He saw no natural equilibrating tendencies in the American economy. Although he granted that considerable progress had been made under capitalism he also made the critical assumption that capitalism's justification in the public mind rested not on this practical basis, but on the awe of great men (Tilman, 1993; Sowell, 1967). Obviously, Veblen did not ascribe to the 'awe of great men' concept, arguing that maximum economic growth is governed by technological advancement, and that the rate of economic growth cannot be maximized if all output is not serviceable and if efficiency is sacrificed to profit (Tilman, 1993).

Market power plays a significant role in his economic theory. He argued that severe business cycles occur because of a sabotage of production or a conscientious withdrawal of efficiency by businessmen. In general, the capitalist production system (mass production) leads to a general glut, so this 'game' of sabotage is a necessary part of capitalistic society. As capitalists decide to operate below full capacity, keeping prices and therefore profits at reasonable levels, they create the scarcity in the system. They control the system for their own use, and of course, their own use means the creation of profit, no matter the social cost.

As an economist, Veblen argued that the temptation of economists to give practical advice lead them to take the status quo for granted. He posits, in his work on *The Higher Learning in America*, that

It is usual among economists, e.g., to make much of the proposition that economics is an ‘art’ – the art of expedient management of the material means of life; and further that the justification of economic theory lies in its serviceability in this respect. Such a quasi-science necessarily takes the current situation for granted as a permanent state of things... to be safeguarded with apologetic defense at a point where it is not working to the satisfaction of all parties (pp. 186-187).

Capitalism is a social system that does not naturally generate equality, and vested interests have no incentive to change that. Veblen argues that social progress would require the constant examination of existing institutions, replacing ceremonial ones with instrumental ones; an act that would require social awareness and activism from all social classes.

### **Theoretical Summary**

For purposes of this work, I have identified five ideas found in Veblen that are representative of his thinking, of enduring significance, and have substantiated the organizational and cultural development of medicine, as I have experienced it. Although these principles have not previously been applied to the social institution of medicine, they speak directly to it. The next two chapters will demonstrate, through interpretative analysis that the application of his theories should not be limited to simply what has been done before. According to Veblen himself,

The well-worn paths are easy to follow and lead into good company. Advance along them visibly furthers the accredited work which the science has in hand. Divergence from the paths means tentative work, which is necessarily slow and fragmentary and of uncertain value (1906, p. 589).

The first idea is his emphasis on “instincts,” those inherent dispositions that provide the foundation for the cultural development of society through which processes and structure evolve. The second is status emulation, which emphasizes the power that invidious patterns of behaviors have on individuals, our social stratification, and the formation of our social institutions. The third idea is his ceremonial-technological dichotomy, which pits business against industry by stressing the differences between making money and socially useful goods, putting the emphasis on profit instead of community serviceability. Fourth are his thoughts on institutions and the lag that is created by the resistance of powerful vested interests to change the status quo, while powerless others lay witness to the dynamic advances of science and technology. Lastly, there is his theory of market capitalism in which severe business cycles, caused by the “bankruptcy” of commercial values, stand in the way of social reform. All of these ideas, I will argue, have manifested themselves in the cultural and organizational development of medicine.

Veblen gave us ideas and insights with which to better understand the subtleties of cultural forces and social pressures on industrial life. He highlighted, albeit with a bit of comic relief, the reality of human “instincts” and how they impact the structure of society. And he did all this, according to John Diggins, while keeping his own individuality stubbornly intact. Therefore, should we be so concerned with his ambiguities, inconsistencies, and personal discontents, or should we merely accept his alienation as a

lens through which we are able to see a different perspective of our culture, our society, and our world? After all, “The world owes its onward impulses,” advised Nathaniel Hawthorne, “to men ill at ease” (Diggins, 1999, p. 230).

## CHAPTER IV

### CULTURAL DEVELOPMENT OF MEDICINE

The greatest distance between people is not space, but culture.

Jimake Highurata

In America, the culture of medicine did not develop along the same lines as the English model of the eighteenth century. English physicians represented what has been referred to as a “status profession” rather than an “occupational profession” (Star, 1982). They were defined by privilege rather than by labor. They declined to work with their hands and only observed, contemplated, and prescribed while the surgeons, who were considered within the same rank as barbers, engaged in the manual tasks. Since the elite physicians of England had no reason to migrate to America, physicians in the colonies took on a very different role, and because they did not serve such a prestige-oriented society as the English, that role took a very different form.

All types of people took up medicine in the colonies, and subsequently they all took the title of doctor. Many of them took on that role in conjunction with another, such as clergymen, midwives, and owners of mercantile shops, who besides flour and fruit, sold drugs, or in addition to ladies dresses and bonnets, cured ringworm.

Before the twentieth century the role of the physician in America did not confer a clear and indisputable class position. There was wide spread inequality among those who practiced medicine; their social position was not necessarily low, but ambiguous. If they served the elite, their position was more elite; however, if they served the rural and the poor, their position was certainly less prestigious. Their status depended more so on their

family background and the status of their patients than on the nature of their occupation (Star, 1982).

Medicine, having formed its national association in 1847, made the decision to evolve as a professional entity rather than a trade union. It was this initial decision that placed it in a regulatory environment that favored professional rather than business interests (Wolinsky, 1988; Hafferty, et al, 1995). As a profession, the occupation of “physician” achieved autonomy, which according to Friedson (1970) involves a two-stage process. On the one hand it does reliable and valuable work, which is supported by educational requirements, licensing procedures, a code of ethics, and has the foundation of a professional association along an element of peer review. On the other hand, it possesses an extensive service orientation, which has to be substantiated by the public. If society is convinced of these two things, autonomy is conferred. As a result, the profession began to gain authority in the early 1900s. Its wealth and status clearly defined the culture that would eventually lead to an institutional environment that would provide the framework and meaning for its organizational development. This accumulation of cultural authority was attributable to two things; consensus and legitimacy. Consensus in that the common interests toward standardizing educational and licensing requirements began to mobilize group efforts, and legitimacy in that the attainment of respect began to open the way to additional resources and privilege, thus reinforcing status (Star, 1982; Shryock, 1979; Friedson, 1970).



## Cultural Authority

By the mid 1900s this increased acceptance of medical authority had given birth to paternalistic behaviors. Because each clinical decision involves so many judgments of facts and values, medicine, in its highest form, is an art. This atypical art form is supported by the knowledge control that exists between physician and patient. Parsons (1975) refers to this knowledge difference as a “competence gap,” and it is this gap between the physician and patient that justifies both the professional’s assumption of authority and the patient’s trust, confidence, and norm of obedience. As a result, paternalistic behavior was what patients came to expect, further elevating the status of the physician.

Also, during this time, Herbert Marcuse was writing *One-Dimensional Man*, which reflected the stifling conformity of the 1950s and 1960s. He was disturbed by the new modes of domination and social control, and also by the decline of authentic individuality; a trait that he so highly valued. These one-dimensional individuals were seen as conforming to existing thought and behavior, lacking a dimension of potentialities that could transcend the existing society (Marcuse, 1964). It was this type of individual in particular, no doubt, that embraced the paternalistic behaviors and attitudes of physicians. Likewise, in *The Birth of the Clinic*, Michel Foucault, argued that the Enlightenment had glorified the *clinical gaze*, promoting an exaggerated trust in the wisdom of the doctor, and modernity, with its new breed of myths, saw fit to continue these myths with very little critical questioning. This word “*gaze*,” which for Foucault was a technical term, was acquired through the observation of patients. It was a practical

wisdom that physicians learned through experience, not necessarily through texts, and because of this there was no way for anyone to challenge them.

All of these points served to further elevate the status of the medical profession, and with this new social stability, status emulation and invidious behaviors became woven into the culture. The profession initially struggled to survive, but survive it did.

Veblen, who regarded humans as a product of Darwinian evolution, felt that in the struggle to survive, three basic instincts develop; the instinct of workmanship, parental bent, and idle curiosity. He argued that these instincts were deep qualities or attributes of the human condition, and while people struggle to survive inequality, conflict, and oppression these malleable instincts may become somewhat distorted, but yet still remain intact (Patsouras, 2004). So, the human propensity for purpose, the general concern for the common welfare of mankind, and the knowledge that ideas will eventually be turned to useful ends, all of which are cardinal attributes of the medical profession and tenets of the Hippocratic Oath have somehow survived, albeit in modified form due to technological and scientific progress. The culture of medicine, a once weak, divided, low status and low income profession prior to the 1920s has become a dominant, unified, high status and high income occupation, bound up in leisure class status, values, and behaviors.

Interestingly enough, Veblen's critique of higher education, this ideal that on the one hand there is a disinterested scholar searching for the truth while on the other hand there are the demands of the university to make a profit, could be aptly applied to medicine. There is this ideal that on the one hand there is a physician-scientist discovering and delivering the cure, while on the other hand there are the demands of

corporate medicine to deliver the goods, profit for the medical industry. I argue that this business-culture element has allowed the institution of medicine to become more authoritarian, viewing the producers of medical services as mere employees, endangering the progress of technology, and inviting the competitive, exploitative environment in which we find ourselves today.

### **Culture of Narcissism**

Status is directly associated with power and as the medical profession secured cultural authority, power ensued. With power, came prestige which then opened the doors to privilege. Status, power, authority, and privilege are desired traits to be emulated and through social competitiveness and invidious behaviors, the middle class was created, thereby assuring the leisure class of their continued elite status. Physicians and their colleagues in the medical industry, including hospital, insurance company and pharmaceutical CEOs and administrators, medical consultants, health care financiers, and medical lobbyists have evolved through this culture arriving at what Mestrovic (2003) identifies as a culture of narcissism. These individuals, for whom labor is a derogatory term, have been able to ride the coat-tails of technological and scientific advancement, incorporating, along the way, the concepts of conspicuous consumption, waste, and leisure into their very character. They indulge themselves in order to be seen and envied by others, having no concept of the narcissistic predators they have become. Veblen regards all consumption as determined primarily by the desire to impress others, and only secondarily by the desire for sustenance, comfort, or thrift. It is this envy by others that is the major component of narcissism. On the one hand these individuals are obsessed with

status-consciousness while on the other they seek the admiration and approval of others to verify that status. However, this narcissistic, self-interest is possible only as it accompanies a predatory life and a predatory life is possible only after resources are such that there is a surplus over what is required for sustenance.

However, these individuals do not live in a vacuum, and it is the ever present institutional forces of our society, forces that are beyond their control, that affect their perceptions. In today's society, we are forced to compare ourselves to and judge ourselves by the social position of others. Individuals in the medical profession are no different, except that their culture has historical roots and processes, previously identified, that make the leap to narcissism a mere step.

According to Veblen, the institution of a leisure class has an effect not only on the individual character of the members of society but also on the social structure (1994, p.131). He argues that when a given point of view is accepted in principle as the standard or norm, it shapes a person's habits of thought, which in turn shapes the institutional outgrowth of society. Social evolution is the process of selective adaptation of habits of thought under the stress of circumstances associated with life, and it is this adaptation that results in the growth of institutions (1994, p.132).

### **Institutions and Cultural Lag**

From the mid-1960s radical changes in medicine took place. The culture of medicine now dictated that physicians, forced into a predatory phase of development, become businessmen and entrepreneurs in order to protect their autonomy and preserve their own self interests. Failure to have done so would have meant being left behind,

unable to care for their own patients whose health care concerns and needs were being gobbled up by aggressive managed care companies that were able to convince employers, through advertising and marketing schemes, that their insurance products were both cost saving and efficient.

By not embracing federal and state regulatory changes, adhering to billing and coding regulations, adjusting to overburdening administrative costs, participating in increased health care plans, and compensating some how for reduced reimbursement, physicians would be lost to the predatory capitalistic environment that was of their own making.

While physicians needed to be somewhat creative in the ways they practiced medicine by branching out to capture ancillary service revenue, merging with others to take advantage of economies of scale, and incorporating more effective and efficient business practices, the businessmen with vested interests in larger corporations hesitated to do the same. According to Veblen, this is exactly what would be expected, vested interests resistant to change, working hard to preserve the status quo.

Institutional and corporate cultures, lagging behind technological advancements, only serve to retard growth. For Veblen, institutions are products of past processes, adapted to past circumstances, and because of this they are never in full accord with the requirements or needs of the present (1994, p.119). Case in point, as a society we have been giving lip service to reforming our health care delivery system for years. Lowering health care costs and increasing access has played a large part of every political campaign for the last two decades, yet the system remains the same.

Before addressing the cultural development of the medical business-industry dichotomy, I would like to cite an example of a medical merger with which I am familiar to illustrate the case in point, cultural issues facing medicine today.

### **Medical Merger – Example**

The process of merging medical practices often obscures the original motivations to do so (Mertz, 2001). This particular group had a clear, strategic vision of the new entity; one that now seems blurred. They wished to (1) combine clinical skills in order to service patients with cutting edge technology, (2) create a new facility that would service a new market, (3) allow staffing efficiencies to reduce overhead, (4) achieve economies of scale, and (5) create financial strength, thereby establishing economic and bargaining clout. That vision has been accomplished; however, they underestimated the “human factor.” The merging of practice cultures and philosophies and the transfer of control has been much more of an issue than anticipated. It is somewhat easy to agree in principle and on paper, but altogether different to accept the transfer of control and to anticipate the impact of different personalities. According to Ken Terry (2005), physicians undergoing a practice merger have to constantly work on their interpersonal relationships, or the group will fall apart when the going gets tough.

This particular merger is the result of the coming together of six independent, mature medical groups, all engaged in the single specialty practice of urology. These practices are spread throughout the Houston metropolitan area, and the sixteen physicians involved all provide the complete spectrum of urologic services. There were nine practice locations prior to the merger, and now ten exist as the result of their adding a

prostate cancer treatment and imaging facility, which is centrally located to all practice locations. To minimize the changes made in the day to day clinic operations of the individual practices and maximize the continuity of patient care, the physicians continued to practice medicine in their original locations and their clinical and administrative staffs remained in tact. The six practices differed however in some respects. They ranged in size; one five-man group, three three-man groups, and two solo practitioners. They practiced in different areas of town, from the suburbs to the heart of the city and provided medical care to patients of different demographics, from the indigent on Medicaid to the wealthy, international visitor paying cash for services. The common thread was that they shared the vision of coming together in order to provide a full range of comprehensive, quality urologic services to their patients; services that they could control.

These physicians had a vested interest in their pre-merger medical practices and one would expect that it would take a period of time for formerly autonomous physicians to learn how to make group decisions. Indeed it has, and they have found that cultural transition somewhat painful. The horizontal integration – combining similar medical practices – changed the scale at which services are delivered, billed, and collected. For example, the solo practitioners could not comprehend the volume of sales (professional and technical services) that are processed each and every day. They are upset that each patient’s account does not get the “hands-on” attention that it once did in their small offices. The centralized billing and collections office works accounts on an assembly line process, dealing with revenues in excess of \$2.5 million dollars a month instead of the \$80,000 a month previously collected in their private offices; attention to detail is sacrificed. This one issue alone has caused considerable problems for the new entity.

Vertical integration – increasing the scope of services offered – changed the complexity of the practice by broadening the organization’s domain. By virtue of the merger, they have been able to use their increased financial clout to obtain and implement diagnostic services and provide cancer treatment. Therefore, they can deliver more comprehensive services to their patients, which, if you remember, was the vision. They can also improve their patients’ quality of care as they have the resources needed to spend on services that promote patient safety such as EMR (electronic medical records) and the physicians have daily interaction with colleagues for that valuable second opinion. Small groups can simply not afford to diversify, implement costly technologies, and increase services that provide their patients with a better quality of care. Having said that, these physicians anticipated big savings to be realized from economies of scale that have not transpired; start-up and construction costs have actually increased expenses. Another example is that some physicians are larger producers than others, and while their compensation is fairly based on production, a competitive condition now exists that has the potential to undermine the cohesiveness of the group. These are just a few of the cultural issues that confront medical group mergers.

Stephen Mick, in his book on *Advances in Health care Organizational Theory* (2003), argues the importance of social relationships among actors. He further notes that all behavior, including economic behavior, is embedded in these social relationships. Under the proper management, transition issues are being addressed. Because the merger has involved a loss of control for some physicians, trust is the key issue. Trust requires strong ties in the form of ongoing, permanent relationships that permit frequent opportunities to exchange information, make joint decisions, and build a history of work



experience together. They are working toward that goal. While they attempt to look past most of the irksome behaviors, they continue to embrace the idea of group cohesiveness; a model that will support their being able to deliver quality health care to their patients.

The end result is that the merger process is a difficult one, both culturally and organizationally. However, if there is a good cultural match, a bona fide reason to come together, and a common approach to a specific goal, the potential for a successful merger exists.

Because organizational development is a direct outgrowth of cultural habits of thought, the general landscape of medicine is changing. There is a significant increase in number of physician group mergers and hospital consolidations, the appearance of independent ambulatory care centers, surgical-centers, and free standing imaging facilities, and the expansion of pharmaceutical, medical supply, and health care insurance companies that service the medical industry. This organizational development is occurring because of an increased demand for expanded services in the health care market. However, these increasing businesses serve to make the business-industry dichotomy, of which Veblen speaks, more pronounced; pitting profits against service. This change in organizational development will be addressed in a subsequent chapter.

### **Ceremonial-Technological Dichotomy**

The substantial difference between the peaceable and the predatory phase of culture is a spiritual difference, not a mechanical one. The change in spiritual attitude is the outgrowth of a change in the material factors of the life of the group, and it comes on gradually as the material circumstances favorable to a predatory attitude supervene. The inferior limit of the predatory culture is an industrial limit. Predation cannot become the habitual, conventional resource of any group or any class until industrial methods have been developed to such a degree of efficiency as to leave a

margin worth fighting for, above the subsistence of those engaged in getting a living.

Thorstein Veblen

In medicine today, there is a “margin worth fighting for” as evidenced by the outgrowth of specialized medical services and the companies that support them, which are then supervised by federal and state regulations and the agencies that enforce them. Technological advances in medicine have become a cultural force of wide-reaching consequence and according to Veblen, it is industry, industrial processes, and industrial products that have progressively gained upon humanity until they have taken the dominant place in the cultural scheme (1906, p. 598). Because this technological knowledge shapes people’s habits of thoughts, and because people are active agents and products of the environments in which they exist, they, in turn, have shaped the organization of businesses utilizing this technology. By doing so, through a predatory and competitive system, they have created the dichotomy that exists between business and industry, thereby sabotaging the very system that they themselves created.

Veblen’s concept of the ceremonial-technological or business-industrial dichotomy is representative of a value system, and as such is mutually exclusive. The value system is ‘**either**’ that of business, which is about market value and profit, ‘**or**’ that of industry, which is about the production of purposeful and useful goods. However, the behaviors exhibited within those value systems are dialectical, meaning that they can be either ceremonial (business) or instrumental (technological/industrial), or both. Values define behavior patterns and behaviors, over time, become habits; habits which result in the formation of institutions, like the institution of medicine. While instrumental

institutions, that result from behaviors fostered by good instincts like workmanship, parental bent, and idle curiosity lead to purposeful ends like problem-solving, invention, and innovation among other constructive traits, ceremonial institutions that result from behaviors fostered by bad instincts like selfishness, wastefulness, and sabotage lead to vested interests like fraud, coercion, predation, and self-interest, at the expense of others. Why is this explanation relevant and how is it pertinent to this discussion?

Medicine began as an instrumental institution with, people helping people, addressing social issues dealing with health concerns, and discovering technology that would aid in the diagnosis and treatment of illness and disease. However, most instrumental institutions succumb to ceremonial interests at some point and as vested interests arise, market value and profit become the focus. These vested interests then fight against change to ensure their profit, slowing the progress of the system by a continued and “conscientious withdrawal of efficiency.” This does not mean however, that within the ceremonial-business side of the dichotomy that there are not behaviors that exhibit caring, compassion, and fairness, and that in the instrumental-industry dichotomy there are not behaviors that reflect narcissistic, predatory tendencies. Value systems are dichotomous and the behaviors within those systems exist dialectically.

But for medicine, this dichotomy is particularly bothersome. Physicians (technicians) are responding to corporate interests in growing numbers in order to capture a larger share of health care revenues. They are developing group practices to capture ancillary profits which, in turn, pose an economic threat to hospitals that subsist off of those profits. They are also forming HMOs that help reduce inpatient hospital services, and building surgical centers in which they perform procedures that once occurred in the

hospital. In response, hospitals (business) are opening up outpatient facilities, smaller suburban clinics, and urgent care facilities in order to assure themselves of referrals. As a result, the two are on a collision course, vying for profit at the expense of patient care.

Physicians, however, have somewhat of an advantage in this conflict. They ultimately have the upper hand because they are the ones that have the relationships with the patients and because only they can diagnose, prescribe, and authorize treatment, hospitals are dependent on them for their referrals. But hospitals are not without some advantages in this competitive struggle. Because of the growing number of physicians, they now find themselves in stronger bargaining positions regarding compensation for staff physicians and because state laws continue to restrict hospital expansion, physicians will soon be forced to compete for hospital beds. Apart from this example of hospital-physician conflict, there are many other ways in which medicine is in competition with itself.

As examples, what were once considered normal human problems, such as aging, balding, obesity, menopause, alcoholism, and social anxiety are now viewed as medical conditions. Like it or not, medicine increasingly pervades all aspects of our lives. The consequences of this expansion of medicine through the development of pharmaceutical and biotechnical companies, the growing number of acceptable and reimbursable diagnoses, the support from insurance companies, and pressure from educated, self-interested patients as consumers, only serve to reinforce the cross purposes between business and industry.

The medicalization of non-medical issues is a profit driven business riding on the coat-tails of medicine, relieving patients of the responsibility and accountability for their

own behaviors. According to Gordon Livingston, M.D., in his book entitled *Too Soon Old, Too Late Smart*, a somewhat recent diagnostic fad is that of Adult Attention Deficit Disorder (ADD). He argues that disorganized, day-dreaming procrastinators now have a medical explanation for their inattention and an effective treatment: stimulant drugs. People uniformly report that their spirits are better and that they get more done when taking an amphetamine, to which he replies, “Me too” (2004, p. 33).

These are only a few examples of the ceremonial-technological dichotomy that appear in the social institution of medicine. For Veblen, this pecuniary competitive system is an outgrowth of modern culture – habits of thought induced by the discipline of life. For him, it was always possible that any given phase of culture could give rise to divergent lines of institutional growth, to habits of thought which are mutually incompatible, and which, at the same time, may be incompatible with the continued life of that same cultural situation (1910, p.171).

### **Cultural Summary**

Cultural facts are transmitted from generation to generation. These facts, over time, are etched and imbedded like fossils into our minds becoming the habits of thought that create the institution environments in which we live and work. The institution of medicine is certainly no different as evidenced by its historical transformation outlined by Paul Star in his 1982 Pulitzer Prize winning non-fiction novel, *The Social Transformation of American Medicine*.

Veblen argued that social institutions evolve and subsequently depend upon modern business principles; principles that are pecuniary by nature. According to

Mestrovic (2003), scientists as well as other representatives of social institutions must make money to pursue their humanitarian objectives, and to make money they must participate in competitive and manipulative ways, much the same as a modern day businessman. Today's physician is that modern day businessman, one who finds himself located in the value system that is industry....by providing useful and purposeful medical services....but yet being forced to exhibit both instrumental and ceremonial behaviors in order to survive.

From the rise of professional sovereignty to its transformation into an industry, I believe that medicine, as a social institution, has followed a predictable course; one that was fittingly outlined by the economic and social theories of Thorstein Veblen. His theory of instincts, cultural lag, and status emulation, as well as his thoughts on institutions speak directly to the evolution of the culture of medicine while his thoughts on the ceremonial-technological dichotomy and the effects of market power on capitalistic enterprise have emerged as a template for its development as a modern day institution.

Because culture serves as a pattern for organizational development, development that creates social institutions and social forces that control our thoughts and behaviors, it is necessary to trace the organizational development of medicine in order to understand the over-arching issue. Why, in America, do we have a medical system with incomparable technological advancements struggling to provide its population with comprehensive, affordable, and accessible health care?

## CHAPTER V

### ORGANIZATIONAL DEVELOPMENT OF MEDICINE

The material framework of modern civilization is the industrial system, and the directing force which animates this framework is business enterprise..... The business man, especially the business man of wide and authoritative discretion, has become a controlling force in industry, because, through the mechanism of investments and markets, he controls the processes, and these set the pace and determine the direction of movement for the rest.

Thorstein Veblen

Such is the organization of medicine. Many analysts define organizations as *social structures created by individuals to support the collaborative pursuit of specified goals* (Scott, 2003). While some organizations process new equipment and fabricate materials, others process people; their products consisting more of knowledge as in the case of education, or health as in the case of medicine. Given this conception, no organization is self-sufficient; all are dependent on relationships they establish within the larger systems of which they are a part. While all organizations are said to confront common problems such as defining their goals and objectives, inducing participants to contribute services, and then controlling and integrating those contributions, they also must produce goods and services. They cannot achieve all these things without some type of working relationship with the environment in which they exist, and while they utilize resources from the environment, of which only some are devoted to goal attainment, they must take steps to survive. It is precisely the methods of survival that Veblen calls into question.

According to W. Richard Scott, the pathologies of organizational development and operations affect both individuals and communities, having at their root the abuse of

power. Veblen would not disagree. For individuals, the emulative, exploitative, and predatory values, which place business in direct conflict with industry, create alienation, inequity, and conformity. Alienation in that as workers lose control over the products of their labor and develop a sense of powerlessness or apathy, they lose something that is sacred to Veblen, the realization of human potential in work; the loss of their instinct of workmanship. It is this subordination of workmanship to the need for prowess that is the foundation of his theory on status emulation. Inequity in that it presumes, on some basis, the validity of ownership, which confers status; status attributable to honorific or predatory, not productive, pursuits, and voluntary conformity in that individuals are pressured to conform to accepted “cannons of taste” in which only pecuniary interests and invidious behaviors are valued.

For communities, organizations pose significant problems including the sheer visibility of corporate crime and corruption, an inability to maintain responsiveness to public needs and concerns, and a relatively narrow focus on goals that support individual interests. For Veblen, all of these issues would be explained by the fact that the motivating force of capitalism is due to emulation which fosters predation. Predatory behaviors are an outgrowth of the expectations that vested interests have in servicing their own needs at the sacrifice of those belonging to the communities in which they serve.

David Riesman posits that Veblen’s book entitled, *The Higher Learning in America*, can still be read as a guide to the subtle infiltrations of salesmanship into American academic life (1953, p. 110). I would also argue that the book has a striking relevance to the American medical system. Veblen talks about the university as being



“intimately bound up with bureaucratic officialism and accountancy” while working toward pecuniary success. He argues that the intrusion of business principles in the university serves to weaken and retard the pursuit of learning, and therefore to defeat the ends for which a university is maintained (Mestrovic, p. 75). In parallel, the intrusion of business principles into medicine has served to weaken and retard the pursuit of providing affordable, quality medical care, therefore defeating the ends, which is the treatment and prevention of disease and the maintenance of good health for the population at large.

Just as Veblen indicted the university for largely becoming a “business house” of “merchantable knowledge” whose basic purpose it was to serve business, our medical system has become, by virtue of organized medicine, which is backed by the power of the state and federal governments, a despot exercising hegemonic control over health care by determining who can perform which services and how these services are to be delivered and financed.

In *Theory of Business Enterprise*, Veblen insists that the framework of modern civilization is the industrial system, but yet it is business enterprise that directs this effort towards profit. While each industrial unit stands in “close relations of interdependence with other industrial processes going forward, from which it receives supplies, materials, apparatus, and the like – and to which it turns over its output of products, or on which it depends for auxiliary work,” it is business transactions which balance those relations..... And the larger the industrial system, the larger and more far-reaching will be the effect of each business move (1958, p.15). The many industrial units that make up our medical system, from research institutions to pharmaceutical companies, from clinical

laboratories to medical equipment and supply vendors, from hospitals to rehabilitation centers, and from medical clinics to nursing homes, are all interdependent, one on the other, to provide comprehensive medical care to the people of our communities. However, it is big government (Medicare & Medicaid), federal agencies, managed care companies, and large, for-profit, medical entities that dictate the outcome for all concerned, forcing the industrial units to succumb to predatory behaviors in an instrumental value system. The researchers, medical technicians, pharmacologists, biologists, physicians, and others involved in the intellectual work of the industry prepare the way for the businessmen of pecuniary affairs by “making possible and putting in evidence the economies and other advantages” that will follow, thereby making profit possible. According to Veblen, the ulterior end sought is an increase of ownership, not industrial serviceability (1958, p.24).

During this process, sabotage emerges. For Veblen, men in industry, in this particular case, technicians, medical researchers, physicians, inventors, and the like must create the mechanical possibility of new and more efficient and effective methods, medications, treatments, and cures before businessmen see the chance, make the necessary business arrangements, and enact the pertinent legislation required prior to the utilization of those technologies. It is that period, according to Veblen, between “the time of earliest practicability and the effectual completion of a given consolidation” in which businessmen retard the advance of industry, thus sabotaging the very system on which they are dependent. This is perhaps best illustrated by several pertinent examples. First, the medical community tries tirelessly to obtain approval, by the FDA, for the use of certain drugs and treatments that have been clinically proven effective and are widely

utilized in other countries. These other countries, which have less government regulation regarding the approval of new medical technologies, then become a haven for American visitors who seek available, cutting edge treatments not available to them here in America; taking revenues from and more importantly confidence in our health care system abroad. Additionally, pharmaceutical companies protect patents that guarantee large profits. They are reluctant to allow other available medications that would effectively treat these same medical conditions, because again, it decreases their profits.

Secondly, by enacting restrictive legislation, physicians are prohibited from capturing revenues from ancillary services such as laboratory and imaging, thus forcing physicians, who are merely trying to offset the reduction in reimbursement for medical services, to form competitive alliances. By allowing physicians to incorporate ancillary services into their practices, it allows for more comprehensive, less fragmented medical treatment for patients who would then no longer have to go to the laboratory to have their blood drawn, then to an imaging center to have a diagnostic scan, and then to the hospital for an outpatient procedure that could have easily be done in the office. The result is better care at a cheaper cost, both to the patient as an out-of-pocket expense and to the insurance payer. By restricting these services, which fosters predatory behaviors, it merely serves to further fragment the medical system, making it even more difficult to accomplish its purpose: affordable, accessible, and quality health care for everyone.

Third, there are the issues regarding inducements for services. There are continual efforts of our government to legislate against pharmaceutical companies, medical supply companies, and hospitals who offer inducements for physician prescriptions, equipment purchases, referrals, and services. The costs associated with this

effort are passed on to the consumer, i.e. the patient, who unwillingly absorbs it through the increase in their health care premiums. These companies, although they are health care related, do not provide health services to individuals. For Veblen, “employers pay the wages of these persons, not because their work is of productive benefit to the community, but because it brings a gain to the employers.....the point to which the work is directed is profitable sales” (1958, p. 35).

In Riesman’s book, entitled *Thorstein Veblen, A Critical Interpretation*, he gives a concise summary of the movie, “The Big Carnival,” and equates it to a Veblenian parable, in which the relationship between business and industry implodes, leaving no survivors. It begs the question – is medicine is on that same path?

In the movie “The Big Carnival” a man is pinned in a cave by falling timbers. For a cynical newspaperman, his plight is a “find” and he proceeds to “mine” the man out by drilling through the top of the mountain in which the cave is located, rather than going in through the direct, commonsense passage which would extricate him too soon and spoil his news monopoly – and spoil also the carnival-like monopolies of hawkers and other prehensile folk who are making a good thing out of the crowds who come to watch the drilling. In the course of these businesslike proceedings, a matter-of-fact and experienced engineer-artisan appears, and asks why they don’t go directly after the trapped man, who all this time is suffering and is further tormented by the pounding drills overhead. But the interloper lacks the gift of gab and control of communication channels, and after making his point into the mike, the engineer is fended off by astute questioning - industry succumbs to business. But in the end business succumbs too; the trapped man dies, and as the Vested Interests have a falling out, the newspaperman loses his monopoly, and is shot by the dead man’s rapacious wife. The Carnival is business, blithely carrying on its sabotage of the life process, while pretending to be helpful and industrious, and diverting the paying customers by means of clamor and glamour. But it, too, perishes in the end, having pushed its control of industry to the point of strangulation. And the Vested Interests in the case, being predatory, not only succeed in killing the very goose they depend upon, but also fall upon one another, in a paradigm of modern war-making (1953, p. 81).

## **The Medical Organization**

Organizations do not simply influence individual behaviors but are actually actors themselves, possessing resources, exhibiting distinctive capabilities, and containing limitations. After years, even decades, of watching an industry maintain a remarkable level of stasis, despite revolutionary technological discoveries, the health care industry now stands at a crossroads. It faces a dichotomous situation that of rapid change in a sector noted for its highly institutionalized character (Scott, 2000). No longer are the solo practitioner and the independent, voluntary hospital the dominant forms of health care delivery. While all social processes, including organizations, exhibit change, it historically does not come easily, nor is it swift. Organizational change is usually continuous and incremental. However, in the case of medicine there have been two instances of discontinuous change that appear to have launched a once privileged, professional sanctuary into turmoil.

The first occurred in 1965 with the entry of federal government into the health care arena as the largest purchaser of health services, signified by the Medicare/Medicaid Act. This event unleashed a vast amount of federal funding but also unleashed legislative restrictions, the likes of which medicine had never witnessed. The second was also legislatively mandated. It was the federal acts of 1982 and 1983, to curtail hospital costs and to encourage competitive processes in health care markets (Scott, 2000). These two events alone have vastly changed the landscape of American health care. Medicine has now become a marketable commodity. Subsequently there has been a rapid rise in numerous types of health service corporations and medical advertising and sales firms, all competing for their share of the health care dollar. As a result, several significant trends

have emerged that are taking health care in a new direction. These trends, which include increased specialization, diversification, privatization, and market orientation, will be discussed in detail in the next chapter when I examine the future of health care.

There is no doubt that Veblen directly addresses organizational development throughout his works. By citing the following two examples, I argue that his theories are both relevant and pertinent to the development of medicine.

### **Organizational Building Blocks of Medicine – Example**

According to David Riesman, there is a danger of over-applying Veblen to an altered situation but, he argues, the danger is less pressing in writers of a more uncompromising concreteness. I find numerous parallels in Veblen's work that are applicable to the contemporary institution of medicine and this analogy is an attempt to raise awareness and draw inferences where none have existed before.

I have identified five building blocks of our U.S. health care system, which I call the components of our medical institution. It is to each of these building blocks that I will apply particular tenets of Veblen's ideology helping to explain their purpose and function. The first building block is made up of "*consumers*" and this category includes patients, patient advocacy groups, nursing home residents, and other institutionalized patrons. The second block is that of "*professions*," which includes physicians, nurses, technicians, physician extenders, managers, and hospital and insurance company administrators. The third building block is that of "*divisions*," which includes medical work groups, multidisciplinary teams such as those found in hospice, surgical teams, and administrative groups, the latter including hospital admission and pre-registration units.

The fourth building block is “*health organizations*,” which are made up of hospitals, nursing facilities, rehabilitation centers, medical clinics, group practices, and insurance companies. The last building block is that of “*related health organizations*,” which refers to Federal/State and local governmental and regulatory agencies, accreditation bodies like the AMA (American Medical Association), professional societies like the ACS (American College of Surgeons), medical schools, pharmaceutical companies, and the medical establishment itself.

### *Boundary Spanning Activities*

These five building blocks make up the social structure of the medical institution and they work closely together with the cutting-edge advances in medical technology as a multi-level organization in tandem with the environmental context in which it functions. In addition to the five building blocks, it is worth mentioning that there are numerous “boundary spanning activities” that affect how the medical institution functions. It is simultaneously both effecting and being affected by the environment in which it finds itself operating. This informational interchange process suggests relationships between the individual, organizational, and environmental aspects of boundary activity. To expand upon this thought, and before I undertake the conceptual analysis of each building block, we must consider what constitutes boundary spanning activities.

One example is in regard to Veblen’s polarizing distinction between engineers and their allies, and the “class of men skilled in chicanery” in which he included accountants, lawyers, and politicians. The engineers and their allies in medicine are the *professions* and the *divisions* through which their informational exchange across

boundaries in support of one another is in direct conflict with the individuals representing *health organizations* and *related organizations*, who are in turn supporting one another. These two groups, according to Veblen, have different roles in the processes of production: “the former to produce, the latter to interfere with production on behalf of profits” (Riesman, 1953, p. 82). My point exactly, the former to produce and deliver health services to *consumers* and the latter to “sabotage” that production for the sake of profit; the result, the “conscious withdrawal of efficiency” resulting in an ineffective health care delivery system. By restricting access to affordable health care, thus making it a commodity unavailable to a substantial number of *consumers*, people are kept from receiving preventative care that in actuality causes medical costs to escalate, reducing the very profits that *health organizations* and their allies, the *related organizations*, are attempting to produce. Health care is a privilege, not a right, in American society and it is precisely the access to adequate health insurance, granted to some at the cost of the underlying community that keeps the medical institution battling against itself, unable to span its own internal boundaries.

### *1<sup>st</sup> Building Block –Consumers*

The consumer is the foundational building block of the health care delivery system, for without health care consumers, there would be no medical institution. Consumers today are very different from those of decades ago. They no longer engage in consumption for what they need, but for what they want....consumption for consumption's sake. Some are narcissistic, conspicuous wasters caught up in the “honorific value” of advertising, while others still expect and embrace the paternalistic



behaviors of a bygone era; “passive puppets of economic processes they neither control or comprehend” (Riesman, 1953, p. 174).

The later, usually the economically disadvantaged, the uneducated, and the elderly succumb to paternalistic behaviors by the *professions* and *divisions* of the medical institution because to them obedience to authority is a value. Veblen refers to this as “a given proclivity winning acceptance as an authoritative standard or norm of life” further stating that it will react upon the character of the members of the society, which have accepted it as a norm. “It will shape their habits of thought” (Veblen, 1994, p. 131). Paternalism, though usually benevolent in its intent, is coercive by nature, and certain individuals remain powerless to its control. Veblen clearly shuns of any semblance of social agency.

The former, prime examples of Riesman’s other directed individuals, are outwardly narcissistic, while trying all the while to hide their feelings of worthlessness yet seeking the admiration of others. To enhance their self image they fall prey to advertising, which Mestrovic points out is a cultural move toward standardization at the expense of spontaneous human emotions. Medical advertising, which is a contemporary phenomenon, has aided these misguided consumers in the medicalization of natural occurring events. Veblen considers advertising wasteful in that it does less to convey info about a product and more to convey “honorific value.” It adds costs to products (pharmaceuticals) with its packaging and visual images and because of its competitive nature, is barbaric and predatory (Mestrovic, p. 137). According to Veblen, “under the law of conspicuous waste there grows up a code of accredited canons of consumption, the effect of which is to hold the consumer up to a standard of expensiveness and

wastefulness in his consumption of goods” (p. 71). This wasteful spending of time, effort, and money on goods (Botox, Rogaine, and teeth whiteners) and services (stomach stapling, lipo-suction, and derma-abrasion) serve to perpetuate this class of consumer. This waste influences the senses of duty, beauty, utility, fitness, and truth (Veblen, 1994, p. 72).

### *2<sup>nd</sup> Building Block – Professions*

The responsibility for the welfare, health, and safety of the community is supposed to take precedence over other considerations for a group of individuals that we define as the *professions*. They are expected to adhere to high ethical standards, possess special knowledge and skills, and be prepared to exercise this knowledge and those skills in the interest of others. In the case of our medical institution, these *professions* are primarily the physicians, who have become, as a result of the competitive nature of medicine, entrepreneurs in business for themselves. These physicians are at the center of our health care system. The institution they uphold has been built for them and around them. They are the modern predators, contributing to the predatory institution of medicine. These leisure class individuals and others of their “like kind” possessing their same values must “make or obtain money in competitive and often exploitative ways, much like the stereotypical businessman makes money” (Mestrovic, p. 7) in order to pursue their humanitarian objectives. It is no small wonder that these physicians, around whom the institution of medicine revolves, have become narcissists. They, in turn, employ a very large vicarious leisure class whose services are conducive to supporting their reputability, enhancing their well-being, and furthering their fullness of life.

This vicarious leisure class is made up of residents, interns, nurses, physician extenders, office managers, hospital administrators, and ancillary technicians, all dedicated to servicing the needs of the physician. This narcissistic, predatory ethic of the self-made physician turned entrepreneur precludes him/her from becoming, as Giddens suggests, re-embedded. Mestrovic argues that Veblen is much more pessimistic and that this modern era has destroyed the non-narcissistic domains of community and family that would be needed in order for the physician to re-embed (Mestrovic, p. 13). There are however a few “patriarchal holdovers” which are represented by the few remaining solo practitioners of the inner directed era. They are now obsolete, and slowly but systematically being forced out by the competitive and predatory nature of the same medical system that they helped to create.

Veblen also talks about an *acquired bent* as being a strong inclination or interest toward something as in his concept of parental bent being a desire to make life easier for future generations. I argue that the *professions* possess a dichotomous ‘*medical bent*’ toward a sense of solicitude extending to their patients on the one hand and the expansion and profitability of their practice on the other. This position is obviously difficult for the physician and like minded corporate administrators to justify and perhaps, as Veblen points out, the cognitive aptitudes of this task might be best handled by those members of the middle class or vicarious leisure class; the ones that support and owe their place in the leisure class to the servitude of the physician.

Also, in regard to the professions, there are those hospital administrators, insurance company CEOs, and clinic managers that create duties just to make themselves appear and feel purposeful; duties that simply justify their existence. Veblen talks about

the many and polite observances and social duties of a ceremonial nature that are developed to justify these professionals' style and title, yet have no economic value. This make-believe of purposeful employment exists to substantiate their leisure class affiliation. He continues this critique when he talks about the leisure class as being a laggard class, "enabled by its wealth to remain in the backwash of economic development, hence a brake upon the wheels of progress (Veblen, 1994, p. 65).

### *3<sup>rd</sup> Building Block – Divisions*

The concept of *divisions* in our health care system constitutes, from an organizational point of view, groups of individuals that work closely together within a larger system to deliver health care products and services to the *consumer*. These *divisions* are comprised of work teams within pharmaceutical sales, the multidisciplinary service teams in hospice organizations, surgical tech teams in hospitals, and the administrative units located in all types of medical organizations that provide a varied range of services from patient admissions to accounts and billing, and from medical marketing to procedure scheduling. These individuals "know their place, know how to effect certain desired mechanical results, and know how to effect these results in due form" (Veblen, 1994, p. 38). They comprise the vicarious leisure class in that the services they perform are not so much for the individual or *consumer*, as for the "reputability of the household taken as a corporate unit" (p. 41). Their service supports the corporate entity they serve and, as Veblen points out, vicarious leisure is possible only on a basis of hired service.

Veblen's "instinct of workmanship" is also applicable to the *divisions* of our health care system. By workmanship, Veblen assumed a human propensity for activity tailored to the efficient achievement of a specific goal; in this case the goal being the delivery of quality health care products and services to consumers. He made the distinction that this workmanship is not directed toward some ulterior motive, but is an end unto itself that becomes apparent by a "turning outward from the individual to society, a merging of the individual through work, observation, or solicitude in the processes surrounding him" (Riesman, 1953, p. 56). This concept describes the vicarious class within our medical institution. These *divisions* of workers, who handle the "ever-present pressure to be serviceable," (p. 61) adapt to the changing environment of medical technology as well as take the 'load-off' the wasters of the leisure class *professionals*, as they "deck out their wastemanship as somehow useful to the community at large" (p. 62). This vicarious activity occurs outside the realm of their consciousness, as an instinct does not involve reason, but simply reflects a complex response to environmental stimuli; in this case an environment in which the physician holds the power, status, and prestige that these workers seek to emulate.

#### *4<sup>th</sup> Building Block – Health Organizations*

At the health organizational level, hospitals, medical group practices, nursing home facilities, free standing surgical and emergency care clinics, and insurance companies are arguably modern organizations that rest on predatory and barbaric business principles. The representatives of these organizations are "bent upon their own sense of entitlement" and "move toward standardization at the expense of human needs and emotions." They must make money in order to pursue their humanitarian objectives

and they do so in much the same way as the stereotypical businessman makes money, through competitive and exploitative ways (Mestrovic, p. 7). To illustrate this point, we look at three of these ways. First, Veblen recognized that organizations often create the needs that they serve (Riesman, p. 74), and to this degree they are exploitative. The institution of medicine has created the medicalization of our society. By creating medical conditions out of natural occurrences, physicians and the medical establishment have laid the foundational ground work for the creation of new medical disciplines, like palliative care specialists so that we can outsource dying. They have championed the formation of pain clinics indicating to health care consumers that pain is its own separate disease process. Acne, balding, and wrinkles have acquired their own DRG (diagnostic related group) codes making their treatment reimbursable by health insurance, which does nothing but add to the rising costs of health care.

Second, Veblen's dichotomous approach between workmanship and wastemanship can be applied to medicine by utilizing what I previously referred to as a Veblenian parable of the movie "The Big Carnival" (Riesman, 1953, p. 81). In this case, the Carnival is the managed care industry, casually carrying on its sabotage of the medical system, pretending to be helpful and conscientious by containing health care costs, all the while scamming premium-paying patients with the illusion of quality care at an affordable price. Perhaps it too will perish in the end, after having pushed its control of the system to the point of strangulation. This predatory health insurance product or "vested interest" will probably succeed in "killing the very goose they depend upon" and then battle each other to the death, thus giving way to the creation of a new entity, perhaps socialized medicine. In this case of sabotage, it would be always presumed that

the guiding spirit of the managed care insurance system, which is attempting to regulate the nation's affairs, whether by restraint or stimulation, is a wise consideration for the greater good.

Third, the relation of the medical establishment to this economic process is a pecuniary one. It is absolutely predatory in nature; "one of acquisition not production, of exploitation not serviceability" (Veblen, 1994, p.129). This leisure class, that comprises the medical establishment, has found ways to adapt the medical institution in order to provide themselves with the means to acquire private gain and to ensure the continuance of the business processes out of which this gain arises. Pecuniary employments such as these tend to preserve the predatory temperament and are evidenced by ownership, acquisition, and accumulation, which the elites of the medical establishment enjoy.

#### *5<sup>th</sup> Building Block – Related Organizations*

Related organizations within the health care industry include, but are not limited to, (1) federal and state regulatory agencies like CLIA (Clinical Laboratory Improvement Amendments), HIPPA (Health Insurance Portability and Accountability Act), and OSHA, (Occupational Safety and Health Administration); (2) accreditation bodies like the AMA which include the governance of state licensing, continuing medical education and the enigma of the medical establishment itself; (3) medical schools; (4) professional societies like the ACS (American College of Surgeons); and (5) pharmaceutical companies. These related organizations, although they are not directly involved in the delivery of patient care, make up the institutional environment in which our health care system operates.

Veblen's addresses these related organizations through his discussions on the conservation of archaic traits and on industrial exemption and conservatism as they relate to the evolution of institutions. According to Riesman (1953), for being a so-called "institutional economist," Veblen did not recognize that institutions had a very "full-bodied" existence, and when he did, he spent most of his time attacking them for being institutions. Veblen seemed to relate more to individual instincts and then would make a huge leap to the largest aggregates, like the underlying population. He actually did not admit to the need for leaders to be responsible for the strength of institutions, because "he did not want institutions to be vital, but to die" (Riesman, 1953, p. 105). However, because Veblen was a social Darwinist, he did feel that institutions survived as a result of a selective and adaptive process that shaped prevailing attitudes and, in turn, took along with them a selection of individuals that also supported those attitudes, thereby adapting the institutions to the changing environment. This is what has happened within the institutional environment of medicine. With the evolution of the medical establishment and the perpetuation of the medical elite, the need to retain control over the health care system, even if they were not directly providing care, manifested itself through regulatory controls. Restrictive and cumbersome regulatory requirements on entities and individuals that provide patient care have become so burdensome and costly that they are sabotaging the very system they represent. The American Medical Association has felt compelled to follow suit and enforce strict adherence to licensing requirements, demand more rigorous continuing education activities, and illicit more intensive and inclusive medical training from the fewer and fewer accredited schools. Veblen argues that the "development of these institutions is the development of society" (Veblen, 1994, p.118). These



institutions are the prevalent habits of thought that drive the relations and functions of individuals and the communities in which they live. It is a selective, but coercive process.

Veblen makes the point that institutions are products of the past, and, although they evolve, they are never in sync with current attitudes or points of view. It's a type of cultural lag. They never catch up with the progressively changing environment and can never hope to meet the real needs of individuals within the society that they serve. This is because they are run by elites, social conservatives whose opposition to change is instinctive. For these individuals all changes in their habits of thought are "irksome" and for this reason any change to our current health care system, albeit for the betterment of society, is distasteful. That is precisely why the United States, who ranks first in medical innovation and technology, cannot deliver health care to our citizens in a cost effective, or efficient manner.

Veblen's framework can even address the reasons for this efficiency failure. For years there has been a persistent reservation to move toward a model of socialized medicine or to even pursue a variant model based on similar principles; one that could potentially control costs, increase access, and provide a preventative regimen from which all citizens could benefit. The leaders in health care, including individuals in the professions, divisions, health delivery organizations, and these other related health organizations are all members of the leisure class for whom conservatism is "decorous." It is the duty of this social class to retard the movement of progress and conserve what is obsolete. Any change or innovation in the present situation calls for "a greater expenditure of nervous energy" (Veblen, 1994, p.127). This leisure class has a vested

material interest in leaving things the way they are because the process of readjustment involves a mental and laborious effort; one that is reflective of innovation, which, being a lower-class phenomenon, is vulgar (p.124).

For years the medical institution has implemented various plans and made some half-hearted efforts at containing costs and increasing access. These include: (1) the Medicare and Medicaid legislation of 1965 which outlined the payment guidelines that have served as the template for all subsequent insurance products; (2) the introduction of DRGs (diagnostic related groups) which replaced the fee-for-service payment structure; (3) the entrance of managed care which further discounted payments to health care delivery systems and has been the most significant change in our health care environment creating competition; (4) the need for medical advertisement; and (5) the vertical integration of health care providers by larger corporate entities. These changes are somewhat illusionary in that for the leisure class minimal changes have occurred. Even though health care premiums have increased, leisure class consumers still have adequate access and affordable plans with numerous options of care, professionals still make ‘top dollar’ and even new positions and disciplines have been created like those of Physician Assistants (PA), and Nurse Practitioners (NP). Divisions, such as hospice, home health, subacute care, assisted living facilities, and rehab hospitals have benefited, and the health care organizations and related groups themselves, including pharmaceutical companies, are doing a booming business. Why change? According to Veblen, “the revulsion felt by good people at any proposed departure from the accepted methods of life is a familiar fact of everyday experience. Any innovation, we are told, will shake the social structure to its base, reduce society to chaos, or confound the order of nature” (Veblen, 1994,

p.125). The aversion to change has been created by the solidarity of the system of institutions, like the building blocks of our medical system, in which there is an instinctive resistance to change any habits of thought.

Much research has been done on socialized medicine and there are indeed many shortcomings; however, there are ways that a modified form could have the possibility of success. This will be addressed in the following chapter.

### *Organizational Power Play*

In addition to looking at the building blocks of our health care system, one cannot adequately portray the organization itself without examining its power structure, and Veblen has had much to say about power. In general, health organization theory looks at power in two ways: (1) types of power inherent in organizations, which are *reward*, *coercive*, *legitimate*, *process*, and *informational*; and (2) types of power possessed by individuals within those organizations, which are *expert*, *rational persuasion*, and *referent*. I shall examine both.

Referencing organizational power, Veblen recognized that institutions create the needs that they serve and because of this they are largely exploitative (Veblen, 1994, p. 74). *Reward* power is demonstrated by the fact that the previously discussed building blocks are somewhat parasitic in nature. Those professions, divisions, health organizations, and related organizations entice people with monetary compensations, conventions of ownership or partnership, and other pecuniary offerings in order to maintain their power over them. According to Veblen, *coercive* power such as the creation of false needs and products, fraud, deceit, and outright lying are inherent in

organizational enterprise; an extension of the predatory impulse, considered almost as a sport. *Legitimate* power exerted by the health care industry and all organizations under its control comes from the concentration of technology afforded them. Veblen argued that this concentration of power would lead to an unprecedented accumulation of wealth at the expense of those at the other end of the economic spectrum; the health care consumers.

Exercising control over production processes leads to *process* power, which is evident in the bureaucratic complexities of our medical institution. Today's medical technology, imaging innovations, managed care plans, regulatory agencies and the like, which are complex, comprehensive, essentially peaceable, and highly organized (Veblen, 1994, p. 140) work to the advantage of the organization, giving them this *process* power over consumers, their own employees, and other related organizations. *Informational* power is simply a matter of having the information that others don't. Knowledge is power and because there are so many of the building blocks within the health care industry that control the development and dispensing of medical care, our medical institution acquires power. In a brilliant passage from *The Theory of the Leisure Class*, Veblen suggested that "the leisure class was an inhibiting force in society not only because of its exemption from industrial employments but also because its extravagances resulted in starving and impoverishing the lower classes so that these lacked the energy to conceive of change or carry it out" (Veblen, 1994, p.187). The health care system and its related components are using, manipulating, and exploiting people because they have *informational* power that allows them to do so.

As Veblen aged, his belief that business was a parasitic growth on industry became more and more an obsessive theme (Riesman, 1953, p. 92), and this typology of organizational power only serves to illustrate that point. He also spoke of individual power and how that was reflective of organizational structure. In particular, he argued that businessmen make profits not by providing an outlet for the forces of industrialization but by monetary manipulations, restricting output, and interfering with the “engineers” who actually produce the goods and services. This is an example of a person’s ability to influence people, which is reflective of an *expert* or elitist power, one in which an individual’s knowledge base allows them to observably influence and shape others.

*Rational persuasion* is the ability of a person to “sell” a behavior; possibly even selling an irrational behavior in a rational way. Veblen makes reference to this type of personal power in the way that he views “the salesman” as a “person given over entirely to chicanery” (Veblen, 1994, p.188). He illustrates his argument by demonstrating that selling has been built into organizational schemes through consumer research, bolstered through advertising, and ends in the “sale.” This is apparent throughout our health care industry in the form of individuals in pharmaceutical, insurance, managed care, and medical supply and equipment sales. These individuals wield a tremendous amount of power over consumers and professionals, and are completely supported by the medical institution.

Lastly, *referent* power is the type of power that is intrapersonal. It is sort of a charismatic attribute or value that an individual possesses; a certain look that gives them power over others. Physicians still have that power over their patients. Their

paternalistic mannerism coupled with their knowledge base and supported by the organization that they represent has bestowed upon them this authoritative standard. As individuals, Veblen maintained that the leisure class would remain in power and receive the economic benefits of being in power as long as they could appropriate technological skills, tools, and labor. This ability to remain in power and to maintain a dominant class position depends in turn on the creation of institutions through business and government to protect the rights of the leisure class at the expense of everyone else. Our medical institution has done just that.

Power is inherent in any organizational environment and is applicable in both the macro and micro levels of organizational behavior. Power and politics play out together as people jockey for position in the organizations they have help to create and maintain. Veblen felt that the institutions in force at any given time will favor the survival or dominance of one type of character to further reinforce the 'like habits' of minds. They are prevalent habits of thought which maintain themselves through a selective, coercive process that has been handed down from the past. They are products of past processes which are adapted to past circumstances and therefore never in complete accordance with the requirements of the present. He maintained that the "institutions of today do not fit the situations of today" and here, one hundred years later in regard to our present medical institution, he is correct!

### *Summary*

Veblen's presentation of his own ideas seems sometimes both contradictory and ambiguous. However, his depiction of *conspicuous behaviors* like waste, consumption,

and leisure, his “*instincts*” of idle curiosity, workmanship and parental bent, and his thoughts on *type-characters* like Captains, Engineers, and Predators are unmistakably relevant to today’s medical social structure. For Veblen, the shallowness and ostentatiousness of society resulted from the tendency to believe that accomplishment lay in arriving at a condition of wealth and status. How institutions are created and maintained are a reflection of these behaviors and, in his pessimistic and skeptical view, society is caught in a vicious cycle of repetition, ‘like minds’ perpetuating ‘like institutions’, which often fail to address the needs of society.

For a second example, I have incorporated Veblen’s essay on *Manufacture and Salesmanship* illustrating a direct comparison between his organizational table of industry and the structure of medicine.

### **Manufacture and Salesmanship - Example**

Social factors play a critical role in health and health care. If you study human behaviors and social interactions within society and then directly correlate them with the concepts and aspects of health, health care, and the organization of our current health care delivery system, you have entered into the discipline of medical sociology. There are two distinct areas of medical sociology: the sociology **in** medicine and the sociology **of** medicine. The sociology **in** medicine is the study and understanding of social factors and social variables such as age, sex, socioeconomic status, race/ethnic identities, education and occupation and how they are relevant to our physical and mental health. The sociology **of** medicine is the study of the institutional and organizational components of medicine in conjunction with how members of our society relate their expectations and

concepts of the medical profession to the health care delivery system as a whole. I will relate Veblen's concepts to the latter; the medical organization.

Veblen recognized that institutions often create the needs they serve and because of this he felt that they were largely exploitative. He uses, in his essay on *Manufacture and Salesmanship*, an organizational table of industry, which he indicates falls into three branches or divisions: key industries, manufacturers, and farming. The divisions are not clear cut as there exists a level of interdependence between them. Key industries stand at the apex of this table and control the issues of industrial life, manufactures stand in relation to the rest of the community, but their power exists only as a vicarious or delegated power from the management of the key industries, and then there are the farmers, who are too many, too scattered and too widely varied in their work to effect a collective change. These divisions play right into the organizational structure of medicine with the key industries being the major health organizations, which refer to federal/state and local governmental and regulatory agencies like CMS (Medicare), accreditation bodies like the AMA (American Medical Association), professional societies like the ACS (American College of Surgeons), medical schools, pharmaceutical companies, and the medical establishment itself. The manufacturers are at the point of health care delivery; these related organizations are the hospitals, nursing facilities, rehabilitation centers, and insurance companies that increasingly dictate the role of the physician. Because the manufacturers (related organizations) vicariously implement and carry out the competitive skills of the robber barons (key industries) they, in effect, sabotage the entire system. Their "conscientious withdrawal of efficiency" adds layers of bureaucracy, thus constraining the delivery of health care. Veblen points out that the



vested interests of “absentee owners” (key industries), carried out through the vicarious leisure class (manufacturers), and then delivered by the physician (farmer) affects the end product, in this case, health care. Obviously, in this scenario, the farmers are the physicians themselves. They are many, scattered, and varied because of numerous medical specializations.

To further expand, key industries within the health care industry include, but are not limited to: (1) federal and state regulatory agencies like CLIA (Clinical Laboratory Improvement Amendments), HIPPA (Health Insurance Portability and Accountability Act), and OSHA, (Occupational Safety and Health Administration); (2) accreditation bodies like the AMA which include the governance of state licensing, continuing medical education and the enigma of the medical establishment itself; (3) medical schools; (4) professional societies like the ACS (American College of Surgeons); and (5) pharmaceutical companies. These organizations, although they are not directly involved in the delivery of patient care, make up the institutional environment in which our health care system operates.

Veblen addresses these organizations through his discussions on the conservation of archaic traits and on industrial exemption and conservatism as they relate to the evolution of institutions. Veblen seemed to relate more to individual instincts and then makes a leap to the largest aggregates, like the underlying population. He actually didn't admit to the need for leaders to be responsible for the strength of institutions, because “he did not want institutions to be vital, but to die” (Riesman, 1953, p. 105). However, because Veblen was influenced by Darwin, he did feel that institutions survived as a result of a selective and adaptive process that shaped prevailing attitudes and, in turn,

took along with them a selection of individuals that also supported those attitudes, thereby adapting the institutions to the changing environment.

It can be argued that this is what has happened within the institutional environment of medicine. With the evolution of the medical establishment and the perpetuation of the medical elite, the need to retain control over the health care system even if they weren't directly providing care, manifested itself through regulatory controls. Restrictive and cumbersome regulatory requirements on entities and individuals that do provide patient care have become so burdensome and costly that they sabotage the very system they represent. The American Medical Association enforces strict adherence to licensing requirements, demands more rigorous continuing education activities, and elicits more intensive and inclusive medical training from the fewer and fewer accredited schools. Veblen argues that the "development of these institutions is the development of society" (Veblen, 1994, p.118). These institutions **are** the prevalent habits of thought that drive the relations and functions of individuals and the communities in which they live. It is a selective, but coercive process affecting the health outcomes of our population.

Also, in regard to the related organizations (manufacturers), there are those hospital administrators, insurance company CEOs and clinic managers that create duties just to make themselves appear and feel purposeful; duties that simply justify their existence. Veblen talks about the many and polite observances and social duties of a ceremonial nature that are developed to justify these professionals' style and title, yet have no economic value. This make-believe of purposeful employment exists to substantiate their leisure class affiliation. He continues this critique when he talks about

the leisure class as being a laggard class, “enabled by its wealth to remain in the backwash of economic development, hence a brake upon the wheels of progress” (Veblen, 1994, p. 65).

For the physician (farmer), the responsibility for the welfare, health, and safety of the community is supposed to take precedence over other considerations. They are expected to adhere to high ethical standards, possess special knowledge and skills, and be prepared to exercise this knowledge and those skills in the interest of others. However, in today’s health care delivery system they appear to be too interested in, as Veblen would posit, “self-help and sharp practice.” They have pecuniary emulations which have compelled them to exercise both their narcissistic and predatory tendencies. They have become, as a result of the competitive nature of medicine, entrepreneurs in business for themselves. These physicians are at the center of our health care system. The institution they uphold has been built for them and around them. They are the modern predators, contributing to the predatory institution of medicine. These individuals and others of their “like kind” possessing the same values must “make or obtain money in competitive and often exploitative ways, much like the stereotypical businessman makes money” (Mestrovic, p. 7) in order to pursue their humanitarian objectives. They, in turn, employ a very large vicarious leisure class which includes nurses, technicians, and managers whose services are conducive to supporting the physicians’ reputability, enhancing their well-being, and furthering their fullness of life.

These three business concerns, the health organizations (key industries), related organizations (manufacturers) and physicians (farmers), are all competitors for a closed market of consumers: the patient. While pretending to be helpful, caring, and

compassionate these three entities guide the delivery of health care in our society today. Although these groups interact, they have different roles: the latter to deliver health care, and the two former to interfere with that delivery in the name of profit. Now that's sabotage!

By restricting access to affordable health care, thus making it a commodity unavailable to a substantial number of consumers, patients are kept from receiving preventative care that in actuality causes medical costs to escalate, reducing the very profits that health organizations and their allies, the related organizations, are attempting to produce. Health care is a privilege, not a right, in our society, and it is precisely the access to adequate health care granted to some at the cost of the underlying community that keeps the medical institution battling against itself.

Patients, however, are not completely innocent in this debacle that is our current health care system. Consumers today are very different from those of decades ago. They no longer engage in consumption for what they need, but for what they want: consumption for consumption's sake. Some are narcissistic, conspicuous wasters caught up in the "honorific value" of advertising, while others still expect and embrace the paternalistic behaviors of a bygone era; "passive puppets of economic processes they neither control or comprehend" (Riesman, 1953, p. 174).

The later, usually the economically disadvantaged, the uneducated and the elderly succumb to the paternalistic behaviors of the medical institution because to them obedience to authority is a value. Veblen refers to this as "a given proclivity winning acceptance as an authoritative standard or norm of life," further stating that it will react upon the character of the members of the society, which have accepted it as a norm. "It

will shape their habits of thought” (Veblen, 1994, p. 131). Paternalism, though usually benevolent in its intent, is coercive by nature, and certain individuals remain powerless to its control (Suber, 1999; Brock, 1988). Veblen clearly shuns of any semblance of social agency as he sees individuals as cultural products, merely acting on habits of thought as reinforced by their environment.

To enhance their self image, patients often fall prey to advertising, which Mestrovic points out is a cultural move toward standardization at the expense of spontaneous human emotions. Medical advertising, which is a contemporary phenomenon, has aided these misguided consumers in the medicalization of natural occurring events, such as aging and balding. Veblen considers advertising wasteful in that it does less to convey information about a product and more to convey “honorific value.” It adds costs to products (pharmaceuticals) with its packaging and visual images and, because of its competitive nature, is barbaric and predatory (Mestrovic, p. 137). According to Veblen, “under the law of conspicuous waste there grows up a code of accredited canons of consumption, the effect of which is to hold the consumer up to a standard of expensiveness and wastefulness in his consumption of goods” (p. 71). This wasteful spending of time, effort, and money on goods (Botox, Rogaine, and teeth whiteners) and services (stomach stapling, lipo-suction, and derma-abrasion) serve to perpetuate this class of consumer. This waste influences the senses of duty, beauty, utility, fitness, and truth (Veblen, 1994, p. 72).

As I have mentioned in previous chapters, the institution of medicine has created the medicalization of our society. By making medical conditions out of natural occurrences, they have laid the foundational ground work for the creation of new medical

disciplines, like palliative care so that we can even outsource dying. They have championed the formation of pain clinics indicating to health care consumers that pain is its own separate disease process. Acne, balding, and wrinkles have acquired their own DRG (diagnostic related group) codes making their treatment reimbursable by health insurance, which does nothing but add to the rising costs of health care; conspicuous waste.

Veblen also discusses *acquired bent* as being a strong inclination or interest toward something, as in his concept of parental bent being a desire to make life easier for future generations. I argue that physicians possess a dichotomous '*medical bent*' toward a sense of attentiveness, extending it to their patients on the one hand and to the expansion and profitability of their practice on the other. This position is obviously difficult for the physician and like minded corporate administrators to justify and perhaps, as Veblen points out, the cognitive aptitudes of this task might be best handled by those members of the middle or vicarious leisure class; the ones that support and owe their place in the leisure class to the servitude of the physician.

Another of Veblen's central concepts, the "instinct of workmanship" is also applicable to our health care system. By workmanship, Veblen assumed a human propensity for activity tailored to the efficient achievement of a specific goal; in this case the goal being the delivery of quality health care products and services to consumers. He made the distinction that this workmanship is not directed toward some ulterior motive, but is an end unto itself that becomes apparent by a "turning outward from the individual to society, a merging of the individual through work, observation, or solicitude in the processes surrounding him" (Riesman, 1994. p. 56). This concept actually describes the vicarious leisure class within our medical institution. These workers, who handle the "ever-present pressure to be serviceable," (p. 61) adapt to the changing environment of

medical technology as well as take the ‘load-off’ the physicians as they “deck out their wastemanship as somehow useful to the community at large” (p. 62).

Organizationally, as I have previously mentioned, Veblen parallels William Ogburn’s concept of cultural lag by making the point that institutions are products of the past, and although they evolve, they are never in sync with current attitudes or points of view. They never catch up with the progressively changing environment and can never hope to meet the real needs of individuals within the society that they serve. This is because they are run by elites, social conservatists whose opposition to change is instinctive. For these individuals all changes in their habits of thought are irksome and for this reason any change to our current health care system, albeit for the betterment of society, is distasteful. That is precisely why the United States, who ranks first in medical innovation and technology, cannot deliver health care to our citizens in a cost effective or efficient manner. Our life expectancy ranks 24<sup>th</sup> among the countries of the world because we cannot figure out how to tailor our health care system to best serve our population (WHO, 2000).

Veblen’s ideas address the reasons for our failure to do so. For years there has been a persistent reservation to move toward a model of socialized medicine or to even pursue a variant model based on similar principles; one that could potentially control costs, increase access, and provide a preventative regimen from which all citizens could benefit. The leaders in health care are all members of the leisure class for whom conservatism is decorous. It is the duty of this social class to retard the movement of progress and conserve what is obsolete. Any change or innovation in the present situation calls for “a greater expenditure of nervous energy” (Veblen, 1994, p. 127). This

leisure class has a vested material interest in leaving things the way they are because the process of readjustment involves a mental and laborious effort; one that is reflective of innovation, which being a lower-class phenomenon, is vulgar (p. 124).

For years the medical institution has implemented various plans and made some half-hearted efforts at containing costs and increasing access, all of which have been previously discussed. For review, these include: (1) the Medicare and Medicaid legislation of 1965, which outlined the payment guidelines that have served as the template for all subsequent insurance products, (2) the introduction of DRGs (diagnostic related groups) which replaced the fee-for-service payment structure, (3) the entrance of managed care, which further discounted payments to health care delivery systems and has been the most significant change in our health care environment by creating competition, (4) the need for medical advertisement, and (5) the vertical integration of health care providers by larger corporate entities. These changes are illusionary in that nothing has changed for the leisure class. Leisure class consumers still have adequate access and affordable plans with numerous options of care, professionals still make ‘top dollar’ and even new positions and disciplines have been created like those of Physician Assistants (PA), and Nurse Practitioners (NP). Related organizations such as hospice, home health, subacute care, assisted living and Alzheimer facilities, and rehabilitation hospitals have benefited, and the health care organizations themselves, including pharmaceutical companies, are doing a booming business. Why change? According to Veblen, “the revulsion felt by good people at any proposed departure from the accepted methods of life is a familiar fact of everyday experience. Any innovation, will shake the social structure to its base, reduce society to chaos, or confound the order of nature” (Veblen,



1994, p. 125). The aversion to change has been created by the solidarity of the system in which there is an instinctive resistance to change any habits of thought.

However, our medical system is in need of change, is presently undergoing that change, and is struggling with the effects. Looking at the “key industries” inherent in medicine as outlined by Veblen, we have gained another perspective of how we might examine the structure and make recommendations for modifications that would benefit everyone.

### **Summary**

While both of these examples speak to the organizational development of medicine, neither bring forth solutions to the issues that the industry is experiencing nor insight into the direction that health care is currently taking. What is crystal clear is that we need a better understanding of the relationships between the organizational, cultural, and environmental forces inherent in the medical industry. This is crucial because only with this information and insight can our policymakers, practitioners, and health care administrators provide a better structure through which more individuals can experience good health and receive quality medical care.

## CHAPTER VI

### CONCLUSION

#### Review of Medicine

Veblen argues that although it is a “tedious truism,” institutions of today do not fit the situation of today; that institutions, being habits of thoughts, points of view, and mental attitudes, are always archaic because they reflect a conservative factor, one of social and psychological inertia (1994, p. 119). For him social advancement, especially from an economist’s point of view, is a continuous, progressive approach to “the adjustment of inner relations to outer relations.” However, this adjustment is never definitely established because the outer relations are in constant flux as a consequence of environmental change as well as individual aptitudes. So the capacity for growth of a social structure or institution depends on the “degree of exposure of the individual members to the constraining forces of the environment” (1994, p.120). The institution of medicine, as evidenced by the preceding chapters, is struggling to adapt.

Through an examination of Veblen’s theories of “instincts,” status emulation, and cultural lag, his explanation of ceremonial-technological dichotomy, and his thoughts on business, including market capitalism, I argue that although he did not directly address the institutional development of medicine, he effectively outlined its progression. Even his book, *The Higher Learning in America*, could be considered a direct reflection, by merely substituting medicine for academia. From the social origins of medicine as an institution, when the health care sector was arguably the most distinctive and isolated social sector from conventional business practices and institutional constraints, to today,

when many of these distinctive features have either disappeared or are under siege, it has fallen short of expectations. The weakening of professional authority and unity, the invasion of market influences and managerial agents, and the continuing escalation of health care costs have undermined the ideological barriers that once protected the medical establishment. The perception is that a once authoritarian, paternalistic, and very powerful industrial force has been thwarted by barbarians; ceremonial administrators with vested interests, armed with managerial logics.

How did they get in? I argue that Veblen tells us how; by broadening the concept of health, by attractively packaging marketing tools, by creating medical practice restrictions through legislation thereby encouraging competition, by pitting technology against business through market capitalism, and by appealing to consumers, encouraging them to take ownership by becoming educated participants for their own health. This is where medicine finds itself today, in turmoil and undergoing radical change. However, as we have all come to understand, change is not necessarily bad, but it is inevitable and it does define progress. According to Veblen it is necessary to address the “imbecile institutions” that impede progress and are not operating in the best interest of the population as a whole. In order to do that the cultural and organizational components of the institution of medicine have to be modified to reflect new habits of thought. For Veblen, everything in society is held together by “habits,” and while some habits are predatory, others are peaceable. So the way to change the institution of medicine, thus improving the overall quality of health care delivery, is to change habits. It’s that simple, that profound, and that difficult. In reality, can quality health care be delivered without considering profit? Could market capitalism tolerate such an adjustment or will the

business-industrial dichotomy be able to incorporate a more co-operative approach where health care is concerned? Will emulatory values continue to dominate the profession or as alternative treatments and the concept of wellness infiltrates the biomedical model of medicine, will other professionals take, from the medical profession, the dominance they once held, more evenly spreading medical authority to others? This would include all health care professionals, physician extenders, fitness educators, nutritionists, and health care consumers actively taking a role in their own health, seeking preventive care and adopting a healthy lifestyle. It would also include organizations such as medical insurance companies becoming more involved in paying for patient education and behavior modification rather than for new procedures to repair what could have been prevented. These types of changes are possible, for cultures evolve and habits change. Subsequently the structure of our institutions change, generally more slowly, but they do change. Our institutions are the outcome of our “habits of thought” and we, as a society, can choose peaceable habits.

Our health care delivery system will no doubt emerge from this process of change as a new product; one that I believe can and will address the health concerns and needs of our population, provide new cures and treatments in an accessible and affordable manner, and help, rather than hinder, in the promotion of wellness and prevention. Just getting there, is proving to be difficult.

For Veblen, the modern scientist is “unwilling to depart from the test of causal relation and quantitative sequence.” Scientists often refuse to seek higher ground for their ultimate synthesis. For Veblen, the sense of truth and substantiality “is not satisfied with a formulation of mechanical sequence” but must be apprehended “in terms of a consistent

propensity tending to some spiritually legitimate end.” Once facts, events, and experiences have been reduced to fundamental truths and reflect definitive reality, the “investigator rests content” (1898, p. 377-378). Because I have four decades of first-hand experience in the changes that have occurred and continue to occur in health care, have now completed extensive research in the sequence of events leading up to those changes, and am currently an active participant in professional associations, seminars, and other educational processes outlining the direction of medicine, I am convinced that a restructuring of the system can and will be achieved, albeit a decade away; one that will reflect a cohesive existence between business and industry, making health a priority for all concerned.

Today a cultural environment exists that Veblen could not have imagined and although his framework provides a strong foundation for analysis and provides valuable insight that may have been overlooked, accurate outcomes cannot be predicted. It is the task of today’s academic researchers and applied professionals to lay new foundations and provide new insights, ones that reflect the current environment.

### **Trends in Health Care**

By identifying what’s happening in medicine today, we can perhaps project and even predict the synthesis those future generations will experience as they navigate the health care system. Since the mid-1960s when Congress enacted the Medicare and Medicaid laws, change has been at the forefront of medicine. As a result of these changes, new tendencies have emerged; ones that have set the stage for more radical

changes in cultural and organizational thoughts and behaviors; changes that go beyond the increased penetration of profit-making.

First, there has been a change of ownership and control. There is now more concentration in regional and national health care markets, physicians are operating more in organizational settings such as large group practices as opposed to independent and solo arrangements, and health care organizations such as hospitals and ambulatory centers operate as components of much larger administrative systems. For physicians, this shift has important implications. Physicians and the organizations within which they function need cooperative relational ties in order to work productively and to create an environment conducive to doing so (Mick, 2003). They need to retain clinical control and in order to do that they need to secure the resources that give them market power for purchases and clout with health plans in order to obtain acceptable levels of reimbursement; large group practices have been the answer. With this one trend alone, relations among actors are modified, which is one way that institutional change occurs.

Secondly, specialization has increased, both in organizations and with individuals. New medical specialties such as holistic alternatives and additional medical disciplines such as geriatrics, bariatrics, and psychoneuroimmunology, which are now legitimized by board certification, have been created. Specialized organizational forms have emerged. Hospice groups, neighborhood health centers, health clinics in local pharmacies, free standing ambulatory centers, Alzheimer day care facilities, and urgent care, rehabilitation, and wellness centers now provide medical services that were once provided in a generalized setting, such as a hospital. Individuals have also become more specialized. Nurse practitioners (NP), and Professional Associates (PA), under the direct

supervision of physicians, now assist patients with general medical issues. Technicians such as radiation, inhalation, and physical therapists are prolific and trained to provide highly specialized services.

Third, there is increased integration and strategic alliance formation. As referenced in my example of a medical merger, both horizontal and vertical integration of organizations have changed the scale on which services are rendered. Horizontal integration brings together like or complimentary organizations which can now, by the virtue of their size, provide services that are unattainable by smaller entities and benefit from economies of scale by the sheer volume of their supply and equipment purchases. This type of integration is leading medicine toward more regional and national corporations and health care markets as opposed to local community sources.

Vertical integration allows increased service availability. According to Richard Scott (2000), it allows hospitals to integrate “forward,” capturing ambulatory services by opening urgent care centers, and integrate “backward” by offering extended care and home health services. Rather than offering a single level of care, organizations are now able to offer various levels and multiple phases of care.

In addition to integration, some medical organizations, which are not legally integrated, have formed alliances in which there is a loose, voluntary, and informal relationship between entities that allows them to preserve their legal identity and autonomy, but also benefit from shared management systems. All of these measures serve to change the social and organizational relationships that exist between and among social actors, thus changing the institutional structure.

Fourth, medical diversification has become prominent in the industry. Health care organizations now offer services that are unrelated to their primary focus. Hospital systems are now in real estate management and development and operate rehabilitation centers and retirement communities. Medical corporations have formed holding companies, giving them a wider interest and participation in the general health care market, sometimes housing both profit and non-profit subsidiaries under one roof. All of this diversification serves to broaden the playing field and, I argue, pave the way to the larger possibility of national health care.

Lastly, there is increased privatization. For-profit systems have increased over the once dominant form of non-profit entities and public organizations have become less involved in providing health services than in past years. According to Richard Scott (2000), even when public funds are involved, the medical services are more often contracted out to private organizations. The argument is that this particular trend has occurred, in part, to reduce the role of government in health care; however, not all parties concerned agree that it is actually working. It is increasingly documented that instead of providing goods and services, public organizations are contracting or outsourcing these functions, merely overseeing their production and delivery. Case in point: privatized plans are taking over, from the government, the provision of benefits and services for Medicare and Medicaid recipients, such as Texan Plus, Renaissance, Texas Health Spring, and Medicaid HMOs, all of which are private, for profit entities.

These trends signify progressive, institutional change within the health care industry, change that will ultimately affect the outcome of our health care delivery system. As previously discussed, when organizational change occurs, cultural change



lags behind. Both organizational and individual thoughts and behaviors, especially those of a conservative nature, those reflecting a vested interest, are reticent. So, the process of sabotage is still apparent. Restrictive legislation, impeding progressive change, still confounds the issue. Health care laws, too numerous to mention, continue to act as institutional barriers to health care strategy; however, the industry trends of ownership, specialization, integration, diversification, and privatization, continue to occur, indicating that the future of health care holds promise.

### **Future of Health Care**

In spite of the pessimism that is evident through out this work, the social institution of medicine does have a brighter future. By having looked at the cultural and organizational development of medicine through the lens of social and economic concepts set forth by one of our more brilliant theorists, I simply raise awareness; awareness that historically our social institutions, though initially conceived for the greater good, appear to lose their way. They become animals of a different color, so to speak, their original focus distorted by the “virtues” of big business through market capitalism, vested interests through status emulation, and bureaucracy through regulatory constraint; eventually resembling nothing like the institutions which were intended. That doesn’t mean however, that they are not capable of reform, perhaps returning to their original intent and beyond. For it is the relationships between social actors, the individuals and organizations, that create these institutions, and relationships can and do change.

Over the past fifty years medicine has gone through radical change; however, many would say it has made for an unqualified transformation. Different groups have been dominant at different times during this period, each with a different perspective on guiding the direction of our health care system. Initially physicians, placing the ultimate value on quality medical care, allowed nothing, not even financial concerns or competition with other providers to compromise this relationship. Then public administrators, who viewed health care more in terms of a population than an individual, dominated the scene. Their mantra was that access to adequate, not necessarily optimal, health care was an important right for all citizens. Lastly, corporate officers, administrators, and policy analysts, who looked at the inefficiencies, redundancies, and waste that had crept into health care, insisted that opening it up to market forces would be the panacea, bringing discipline to what they identified as a non-system. So, who was right?

They all were! Each category has values that should be incorporated into our health care delivery system. Physicians do need sufficient discretion to treat the needs of individuals, without having to answer to the restrictions of insurance plans and drug formularies, or feeling obligated to do unnecessary medical testing, or being buried by burdensome paperwork, required referrals, or mandatory authorizations. Highly specialized physicians should take on only highly specialized cases, returning the routine care of patients to primary care physicians, where ongoing health education should be a priority. Public administrators are also correct to insist on the access to health care. Not just our elderly (Medicare) and our poor (Medicaid) deserve quality health care, but the forty-seven million uninsured people do as well; however, too much public funding,

exacerbated by rising expenses, creates severe cutbacks that only serve to further restrict access to those they are trying to help. Even modest modifications, effecting medical service reimbursement and eligibility criteria, would go a long way to stabilizing our public programs. Lastly, the inclusion of corporate management systems does not necessarily mean the depersonalization of health care. There are many methods of organization and management that, when not restricted to efficiency and include attention to quality, would serve the system well. Health care should include both a private and public side.

There is another group that I have not yet mentioned; the patients. Health care consumers have to become advocates for their own health and health care, agreeing to take on the challenge. Not only do they need to know, understand, and advocate for their health care rights, but they have to take an active part in modifying their own behaviors; behaviors that contribute to many of the health related issues that are responsible for the expenditures of billions of health care dollars. Education and accountability, perhaps in the form of incentives, may help our citizens take an active role in the reform of their health care system. Health care for our citizens is too big to be left to one group of individuals. It will take all of them working together to craft a system that can manage the health care needs for everyone.

### **Assumptions**

In the past, attempts at health care reform have failed, including the recent 1994 defeat of President Clinton's Health care Reform Bill, which had been touted as the answer to our ailing health care system, universal health care seemed just around the

corner. Why did it fail? According to Sherry Glied in her book entitled, *Chronic Condition: Why Health Reform Fails*, it does so for three reasons: a failure to compromise, basing health care policies on false assumptions, and a blatant disregard of financing needs. She cites two groups of reformers: one that supports the single-payer reform and one that supports a market oriented, managed-competition approach. Their positions are so opposite and their motives so different that compromise is impossible; each group in competition with the other, vested interests trying to preserve the status quo while both tout their support of the same ideal: affordable, accessible, and quality health care for everyone. This competitive position brings to light what we all have come to know and understand: health care is a market commodity. It is seen by many from a marketist perspective, as simply another good or service. Until we can move from that position, true reform is impossible. Veblen would not disagree.

How we can take on the reform of our health care system will depend on our assumptions regarding the health of our population. The traditional ways in which we once assumed that patients were passive victims, that health care was event driven and began when a problem arose, that ill health was unpredictable, that physicians were the sole authority on treatment, that health care is something that you pay for so those who can't pay get less of it, and that success was measured by the numbers of individuals that were treated with traumas and disease that had reached acute and symptomatic stages through medications and procedures, should be rethought. Perhaps the future of our medical system depends on alternative assumptions like much of ill health is predictable, that it can be prevented and conservatively managed, that patients will be partners in managing their own health, that physicians will play more of a team role, that we will

manage the costs through population health status improvement, and that one way or another we will all pay for everyone's health care, not because it is the right thing to do, but because it is the only workable solution. These assumptions are not true today and not necessarily shared by everyone, but we appear to be headed in this direction.

There are several key factors that are setting the stage for real reform:

(1) Advances in health oriented telecommunications, imaging, and databasing, now allow physicians to communicate more easily and quickly, administrators to drive their systems in real time, and health plan representatives to increase consumer awareness through interactive, online forums and personal health information systems. Outcomes management systems that scan massive databases to determine what treatments actually work the best is making the practice of medicine more of a science and less of a craft. The ability to measure these outcomes and have this information available to health professionals is invaluable, driving treatment costs down and quality care up. If it is broadly applied it will open the door for alternative and complimentary methods of treatment that will enhance traditional methods, allowing a comprehensive comparison of prevention and intervention strategies. These new technologies are providing the medical system with a new infrastructure, the information highway needed to change the focus from illness to health.

Medical knowledge today is increasing and changing more rapidly than anyone can learn it. We cannot expect the physician to 'know all' but with the widespread use of these management tools perhaps their role will be altered, moving away from knowing facts and moving toward the more human aspects of the craft like making difficult judgments and assisting patients to change their behaviors.

(2) The focus of health care is moving away from acute care and toward prevention. By moving away from the hospital setting and back to clinics, physician offices, schools, workplaces, and even the home, behavior modification and intervention will give way to screening, early detection, and treatment, perhaps offsetting the need for extensive acute and chronic care. Making people partners in their own health care, engaging their families in the process, and integrating the community in the effort to do so, makes it not only more effective to catch disease early and close to home, but cheaper. This focus does two things, opens the way for population health and sets the stage for restructuring the system.

(3) Population health has always been identified as the key to eradicating disease. David Kindig (1997) argues that we will not maximize the amount of health our nation can achieve until a measure of health outcomes becomes the purchasing standard. He further argues that aligning our health system with a strict measurement of health outcomes would require no sweeping legislation, no massive new bureaucracy, and would appeal to both conservatives and liberals, as well as patients, health professionals, business executives and legislators. It is an avenue of health reform that deserves consideration.

According to the National Institutes of Health, about half of all health related issues are a result of behavior and the environment, all of which are preventable. Smoking, excessive drinking, poor diet, and lack of exercise in conjunction with pollution and unsafe working environments combine to create the majority of our health care dilemma. There is no argument that changing the behavior of the population and cleaning up the environment would be a good use of health care funds, but it appears to

be a very utopian idea. Not so, according to the World Health Organization's "Healthy Cities" model; a model that is active in over 1000 cities worldwide where, at the local level, action is being taken to address poverty, poor living conditions, and environmental pollution. They also address health educational in schools and workplaces, all factors that affect the health of our population.

(4) Restructuring the health care system is not the beginning of the process, it occurs as the result. For when we alter the way we manage our health, the system will be forced to change its structure. According to health futurists, those changes are taking place. Acute health care is shrinking dramatically. Within a decade almost one third of all hospitals will close and the rest will shrink in scope, providing fewer services with more intensity. Almost all will be part of larger organizations that incorporate the cooperative efforts of physicians, insurance plans, payment structures, home health agencies, wellness centers, and alternative health solutions. These integrated systems are vast entities, but hold promise for the delivery of total health care for a fixed fee to large groups, i.e. unions and mega employers. The advantage, reimbursement is not made by the procedure or even the disease type, but by the person. These entities will be reimbursed for "covered lives" so they have every incentive to keep their populations as healthy as possible. These so-called capitated plans are not new to the industry, but on the magnitude with which it is predicted, they are projected to change the face of health care delivery. Being paid by the number of lives they insure, these integrated systems will benefit from keeping people healthy, not from treating their disease. What a concept!

Part of our health care structure is supported by public funds through congressional legislation, and despite political rhetoric to the contrary, Congress is not likely to enact significant health care reform any time soon. However, there will be numerous experiments at the state and local levels. Business will continue to become more heavily involved in health care, but in a more cooperative way by working with, not against, physicians and hospitals to contain costs and with local organizations and governments to make the community a healthier place. Several states have enacted their own “universal” health plans, and although some have not been successful, they have learned from their mistakes, made modifications, and are trying it again. It is a process, one that we can ill afford to take lightly.

Attempts to restructure a health care system that focuses on keeping people healthy requires both cultural and organizational modifications. Americans currently distrust the system. They don’t know who to believe, what their motive might be, or how to navigate through a very complex system; one that, in their eyes, makes it almost impossible to obtain quality health care at an affordable price. If we could just bring all sides together, business, industry, and consumers, we might discover that we desire the same thing. For what is demonstrated, over and over, is that, “with the right kind of attention, the bleeding heart liberal, pay for everything position, and the bottom line cost-cutting hard-line position, turn out to be the same” (Flower, 1996).

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The best available scientific evidence clearly shows the way to more effective and efficient approaches to health care: excellent and universally accessible primary care; physical education and healthy foods in schools; health education; and community efforts to promote health child development and healthy aging. Well-informed citizens can do more to improve their individual health and fix what ails the American health care system, but real change can begin only with unbiased information and incentives that promote good health.

With ground breaking advancements in medical research, the technology is available. Treatments and cures unheard of just a decade ago are obtainable. With cutting edge communications and databasing, health education is accessible. Web based tools and medical marketing strategies have opened our minds to the idea of improving health related behaviors. With the diversification of health specialties, cooperative relationships exist between medicine and alternative therapies making it possible to treat the whole person, not just the disease. And, with a strong focus on prevention and early detection, good health is within our reach. The challenge is how to bridge the cross purposes of industry and business that Thorstein Veblen so aptly described, how to utilize the knowledge, skills, and tools that we currently possess for the greater good and not just to line the pockets of vested interests. Thus far in medicine, our behavior has not reflected our intent.

For Veblen, human behavior is not natural, it is shaped by institutions and these institutions require constant examination. Because our inclinations are socially influenced, then enforced, and because industry is in conflict with business, it is our duty, if we are to experience social progress, to constantly modify their purpose. So it is with medicine – an “imbecile institution” being systematically replaced by a new instrumental

one, one that more adequately addresses the needs of the people. In this particular case, the need is good health and quality health care for everyone.

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