corporate America. Raised entirely in the post-Rachel Carson era, they know only the virtue of mass transit and the evil of fossil fuels. They are deeply offended by the levels of executive pay, deplore stock options, and believe that a company's gay rights position is a litmus test for morality. They were but children during the Reagan years, but they recite the Gordon Gekko creed of "greed is good" with great familiarity and believe business spawned the homeless. They equate ethics, not with right or wrong, but with correct views on social and political issues, and certainly not with business.

They have the yearnings of the liberal heart and the values of Dick Morris. That businesses cheat is a given for them, and they are oddly resigned to participation. Cooking the books is not a moral leap for them. Mention the dishonesty in the earnings management techniques of Cendant or Bausch & Lomb and the response is likely to be, "Everyone does that," "That's what MBAs are trained to do," "That keeps a company going—it's hard to know when you've crossed the line."

Such is the result of this generation's students schooled amidst a curriculum and academy aligned against the evils of capitalism and comfortable avoiding the judgmentalism of right vs. wrong. Nothing is evil unless we wish it so, all conduct is relative. Such principles should make for a heck of an economy. Try selling securities in a market where feelings, as opposed to facts, reign supreme.

Business schools are alive in the academy. They are just not doing particularly well and their end products are engaged in the dishonest conduct reflected in today's headlines. Students can't learn good business practices unless and until they are taught that business is good and that it remains good only when it is free from fraud and corruption. Such concepts should not be difficult to impart given economics, business history, and the lessons from the fall of communism. With enough curriculum guidelines on creativity, diversity, and grounded learning, however, the basic premise of the role of capitalism in a free society is lost in the shuffle. If such a loss was the goal of business education reforms, mission accomplished.

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Critical Medical Theory

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Identity politics and other themes in the culture war are beginning to infect the health professions. A major preoccupation of schools of public health, institutions of medical training and research, and the Department of Health

and Human Services is the phenomenon of group-based differences in health status. African Americans, for example, have higher morbidity and mortality for most conditions: cancer, heart disease, stroke, infant mortality, and so on, compared to whites. About that, there is no dispute.

Why these disparities exist and what we should do to reverse them are subjects of legitimate interest. But whether they are the products of racial discrimination in the health care system or in society in general (as the U.S. Commission on Civil Rights, among others, has suggested) is far from clear. Efforts to portray these disparities as the result of bias and to remedy them through civil rights activism are gaining momentum. I call this paradigm Critical Medical Theory. Just as critical legal theory ridicules the idea that color-blind justice could ever flow from a system of laws devised by white men, critical medical theorists believe that health "equality" is impossible to achieve in the current system which was designed by (and presumed to cater to) the majority. There are two manifestations of critical medical theory: oppression theory as it is taught in schools of public health, and affirmative action (racial preferences) in medical schools.

My interest in these disparities began on the morning of 24 October 1996. I literally woke up to a story on National Public Radio about high blood pressure and African Americans. The focus was a study that had been done at the Harvard School of Public Health and that had appeared in the peer reviewed *American Journal of Public Health.* The authors, Nancy Krieger, an epidemiologist, and Stephan Sidney, a physician, had hypothesized that African Americans were more likely to suffer from hypertension than whites—they do indeed have about twice the risk of high blood pressure—because of the stress of being discriminated against. They hypothesized that racial discrimination causes psychological stress, which in turn leads to constriction of the blood vessels and, ultimately, to high blood pressure.

Certainly, we know that stress can have physiological effects, that is not in dispute, but the Harvard study used weak methods. For example, they asked groups of blacks and whites (patients at a Kaiser-Permanente clinic), "Have you ever been discriminated against in your life? Never? One or two times? Three or more?" The responses were then compared with a blood pressure reading on each subject.

If Krieger and Sidney's hypothesis—that blood pressure increases with discrimination—were correct, then the pressure readings would have increased with reported episodes of discrimination. Yet, no such relationship was found. In fact, black working class men and women who reported zero episodes had higher pressure than those reporting one or more. Also, black professional women who reported one or two episodes of discrimination had lower blood pressure readings than those with none or with three or more. And exactly the opposite was found for professional men; that is, men with one or two episodes of discrimination had higher readings than those with none or three

or more. In other words, the results were all over the map. When faced with results that show no pattern, scientists normally conclude that no correlation exists. But Krieger and Sidney were creative. They rationalized that some of the black subjects must have under-reported experiences of victimization or that they had "internalized" their oppression—in other words, they were so beaten down they believed they deserved any poor treatment they got.

Once published, the study received enormous media attention. "Study: Discrimination May Cause Hypertension in Blacks," declared the *Washington Post.* National Public Radio broadcast a lengthy report in which a psychologist who was interviewed about the study said, "We now have concrete data showing that what society does to you affects your health." Brent Staples, an editorial writer at the *New York Times,* wrote a column titled "Death by Discrimination: Of Prejudice and Heart Attacks." Three years later, he was still commenting, going so far as to remark that "the medical system has yet to list 'racism' as a cause of death [even though] some social scientists now see tension related to discrimination as a health hazard on par with smoking and a high fat diet."

I soon discerned that the Krieger–Sidney paper exemplified a major new trend in public health research: the doctrine that sickness is a product of power arrangements in society. This genre of research even has a special name: the social production of disease, and is devoted to the study of forms of social oppression (e.g., classism and sexism) as major contributors to disease. Social productionist researchers like Krieger posit that social disenfranchisement leads to infirmity and shorter life expectancies via two pathways. One is immediate: through the psychological stress of oppression. The other is ultimate: through material disadvantage, which takes the largest toll on the poor and minorities in our society. To be sure, it is a well-known fact that people who are further down on the socioeconomic ladder are, on average, less healthy and shorter lived than those above them. But is people's health utterly at the mercy of social forces?

Some public health experts come extremely close to saying yes. Krieger herself scoffs at the "biomedical model"—the mind-set, typical of physicians and classic public health experts, that holds that patients who are informed and motivated can do a great deal to protect their health. Alas, one is left with the contention that health, too, is socially constructed and, accordingly, the prescription is social reform. This is a far cry from public health's traditional mission of disease and injury prevention. In Nancy Krieger's world, for example, the treatment for hypertension is civil rights.

Conventional public health is aimed at clinical goals like infection control, epidemiological research, and administration of public health-care services. Still, the profession inevitably has a reformist spirit, a spirit that stirred in colonial times, when diseases were understood to depend upon living conditions. Local governments passed sanitation laws and imposed fines for selling putrid meat or for refusing to drain swamps. A movement known as "health

activism" had an important role to play in the decades when such laborers as coal miners and factory workers were forced to work under needlessly hazardous conditions that resulted in severe injuries, lung disease, and other crippling disabilities.

But many scholars and a number of leaders of the American Public Health Association (APHA) embrace an agenda that goes far beyond health care and disease control policies. Indeed, a growing number of professors in schools of public health are advocating explicit stands on policy issues such as civil rights, foreign affairs, campaign finance reform, and affirmative action.

Sally Zierler of Brown University's Department of Community Health teaches a medical school course, "The Health of Women," with the "objective of involving students in public health activism." She has spoken repeatedly of AIDS as "a biological expression of social inequity" and she has determined that the goal of public health professionals should be to overthrow the "competitive meritocracy." In a talk she gave at the 1998 American Public Health Association meeting, Zierler presented evidence of the higher prevalence of AIDs in poor communities—not unexpected. The public health prescriptions that she extrapolated from those statistics, however, are worthy of note: (1) limit the power of corporations, (2) cap salaries of CEOs, (3) eliminate corporate subsidies, (4) strengthen labor unions, and (5) prohibit corporate contributions to politicians. There was nothing about such traditional infectious disease procedures as partner notification of HIV status or contact tracing.

David G. Whiteis, a social production researcher at Indiana-Purdue University, has proclaimed that any public health policy that ignores "social justice is unworthy of the name." Whiteis literally calls for the designation of "poverty as a medical pathogen." These matters make more appropriate subjects for politicians and activists, but social productionists like Krieger, Zeirler, and Whiteis insist that they lie squarely within their purview. After all, since the health status of a population is closely related to wealth and social position, then improving health depends on empowerment.

Now, certainly they are right to point out that the poor tend to be sicker and have shorter lives than the better-off. In part, this is because their access to medical care is limited. But problems also persist in large part because unhealthy habits are more prevalent at the lower rungs of the socioeconomic ladder. That is a widespread understanding. As a remedy, the broad imposition of reform on society is a prescription for disaster, because it regards the patient as a passive victim of malign social forces. Some of the greatest public health successes have involved efforts to change such personal behavior as smoking, unhealthy eating, and unprotected sex. But these practical efforts are far less glamorous than the politically correct goal of "Putting Politics Back into Public Health Education."

This was the title of a panel at an APHA annual meeting orchestrated by Vincent Iacopino, a physician who teaches a course on "Human Rights and

Health" at the University of California, Berkeley. He urged the audience to merge the academy with advocacy, and he supported his quest by citing the World Health Organization's definition of public health. He described it, rather expansively, as the state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

A proliferation of epidemiologists and social scientists is taking schools of public health down the same postmodern path that law schools and education schools have traveled. The focus on social justice has loosened public health from its scientific and clinical moorings. And as the discipline drifts, these academics are trying to prove that the haves are literally making the have-nots sick. This, obviously, is not a scientific agenda. It is a political one.

I'll now turn to disparities in health. In February 1999, a study in the *New England Journal of Medicine* received impressive media attention. It was titled "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," by Kevin A. Schulman of Georgetown University and colleagues. They chose this subject because previous studies had indicated that blacks and women were less likely to undergo cardiac catheterization or coronary artery bypass grafts—even controlling for insurance status. The prior research had been retrospective. Schulman et al. wanted to approach the matter prospectively.

So they recruited about 700 physicians from the attendees at medical conferences. The recruits were told they were participating in a study of clinical decision-making. In fact they were. But they were not told that the independent variables were the race and sex of the patient. They viewed a videotape of actors playing the role of a patient complaining of chest pains in an interview with a physician. The study was well controlled; the actors all read from the same script. Overall, the group of doctors, mostly white, viewed 144 different videotapes, one for every possible combination of race, sex, and age and including differing clinical variables like the nature of the chest pain, the patient's blood pressure, and test results. The physicians were asked whether the patients' complaints appeared to reflect heart disease or another kind of distress, for example, indigestion. Because the physicians rated all eight groups similarly, the authors assumed they would refer for catheterization at similar rates as well.

Yet, according to Schulman, "women and blacks were significantly less likely to be referred for catheterization than white men." About 9 percent of the white men were not referred versus 15 percent of the women and black patients. If representative of actual clinical outcomes, this would mean that blacks and women have a 40 percent lower chance of being referred. Schulman and company speculated in the journal:

> Our findings that the race and sex of the patient influence the recommendations of physicians independently of other factors may suggest bias on the part of the physicians. However, our study could not assess the form of bias. Bias may repre-

> sent overt prejudice on the part of physicians, or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts. Subconscious bias occurs when a patient's membership in a target group automatically activates a cultural stereotype in the physician's memory regardless of the level of prejudice the physician has.

The study was a media sensation. On ABC's *World News This Morning,* Juju Chang told viewers: "How your doctor treats your heart may depend on the color of your skin . . . . The bias shows up in the diagnosis and doctors don't even realize it." Peter Jennings predicted that the study would make "political waves" because it showed that "prejudice among doctors causes a gap in the quality of health care between blacks and whites." On *Nightline,* Ted Koppel was especially inflammatory. "Last night we told you how the town of Jasper, Texas, is coming to terms" with the racially motivated murder of a black man, Koppel said. "Tonight we will focus on [doctors] who would be shocked to learn that what they do routinely fits quite easily into the category of racist behavior." Newspaper headlines echoed the theme: "Cardiac Testing: Study Finds Women, Blacks Are Being Shortchanged," the *Chicago Tribune* said. "Health Care: It's Better if You're White," announced the *Economist* matter-of-factly.

Some of the most intense—indeed, self-flagellating—reactions came from the medical profession itself. An editorial in the *Lancet,* Britain's foremost medical journal, saw the findings as being "as close to a definition of institutionalized racism as doctors and health care providers may dare to get." Aubrey Lewis, a Long Island cardiologist, warned on *Nightline* that "if this [physician bias] continues on, you're looking at literally a decimation of the African-American population." The *Philadelphia Inquirer* quoted a more sober Walter McDonald of the American College of Physicians as saying, "We're going to go to school on this study."

About six months after the Schulman study was published, a powerful rebuttal appeared in the same journal by Lisa M. Schwartz, Steven Woloshin, and H. Gilbert Welch, all physicians at the White River Junction Veterans Administration Hospital in Vermont. They showed that the actual average referral rates for three of the four groups were in fact the same. White men, white women, and black men were all referred at the rate of 9 in 10. Only black women, for unclear reasons, had a lower referral rate: about 8 in 10 were referred. Put another way, black women were 87 percent as likely as white women and men of both races to be referred for catheterization.

Thus, white men were definitely not preferred. Yet, because Schulman and colleagues combined the referral rates for black men (91 percent) and black women (79 percent) to yield an 85 percent black referral rate, they could say with technical correctness that black patients had a 40 percent lower probability of being referred than whites—fifteen blacks out of 100 were not referred versus nine white men out of 100.

In the real world, it is true that health care is less accessible to poor people. Yet, it is important to realize that poor people sometimes make less use of what is available to them. Studies have shown that women with less than twelve years of education are less likely to be screened for cervical cancer or to have pap smears. A study found that women at lower socioeconomic levels were less likely to have breast exams by a physician or mammograms, independent of age, health status, or frequency of physician visits. And scrutiny of the federal vaccine program instituted during the Clinton administration revealed that the problem of low regional vaccination rates was not the unavailability of doctors or vaccines. Instead, it was attributable to the oversight of mothers in not bringing in their children for scheduled shots.

A 1999 study in the *Journal of the American Medical Association* examined the process of obtaining a kidney transplant. Amid the sample of 7,000 patients, the authors found that a failure to complete pretransplantation workup tests and paperwork was far more likely among the African-American patients than the whites. And they concluded: "It appears that many patients remain at this step," referring to the initial step in the process of qualifying for and obtaining an organ. There are four steps, starting with the diagnosis that transplantation is indicated, and more of the black patients remain for an extended period of time without necessary lab tests or they fail to fill out required paperwork. In other words, the determination of who received kidneys depended to some extent on personal decisions—influenced perhaps by fear of the process, by some valid concern, or by a simple lack of interest—rather than on a disregard for the health of minorities and the poor.

Now I would like to turn to affirmative action in medical school admissions. Support for affirmative action programs has become another test of the strength of commitment to minority health. "This is not a quota born out of a sense of equity or distribution of justice, but a principle that the best health care may need to be delivered by those that fully understand a cultural tradition," said George Mitchell, the former Senate majority leader and the chairman of the Pew Health Professions Commission.

Whether the best health care for minority patients truly depends on minority physicians is an interesting question. Proponents of racial preferences in medical school admissions contend that white physicians treat white patients better than minority patients with whom, it is said, they have difficulty developing a rapport. To be sure, understanding a patient's cultural tradition is important, but need one actually be a product of that tradition to be sufficiently sensitive to a patient? Must we employ affirmative action in the form of racial preferences in order to increase the number of minority physicians?

Virtually all of the major medical organizations say yes. Foremost among them is the Association of American Medical Colleges (AAMC). When California and Texas were planning to dismantle racial preferences in 1996, the AAMC formed Health Professions for Diversity, a coalition of major medical,

health, and educational associations, to lobby for the preservation of preferences. By the time Initiative 200, the Washington State referendum to prohibit preferences by race, ethnicity, or sex in public institutions, was on the ballot in 1998, the coalition had 51 associations. According to an association vice president, the true message of race-neutral policy to minority students was this: "We don't want you."

Given the relatively small numbers of black, Hispanic, and Native American physicians (3 percent, 5 percent, and 1 percent of the nation's medical workforce, respectively) compounded by the declining number of minority applicants in the mid nineties, medical schools knew they would need to rely on racial preferences to boost the numbers in the next few years. So a few weeks before Washington State voters were to cast ballots on Initiative 200, the AAMC made a highly visible appeal in newspapers: a full page ad in which eight doctors appeared under a huge banner headline, "The Toxic Side-Effects of Initiative 200."

The AAMC's ad warned readers that without racial preferences in medical school admissions, minority Americans would not get the health care they need. After all, the association argued, minority physicians tend to serve black, Hispanic, and poor patients more often than white physicians and are more likely to practice in poor neighborhoods. As well, minority medical students more often say they want to practice in medically under-served areas. The ad was also quite specific in predicting that fewer minority researchers would mean less progress on sickle-cell anemia, prostate cancer, and infant mortality—all conditions that disproportionately affect African Americans.

Other organizations joined the AAMC in rallying to support affirmative action. The American Medical Association worked with the NAACP and the Mexican American Legal Defense Fund to support the University of Texas in its appeal of the 1996 *Hopwood* decision abolishing racial preferences. The federal government offers minority fellowships for the explicit purpose of training applicants to provide medical services to minority groups. The Council on Graduate Medical Education, part of the Department of Health and Human Services, ranks diversity as its highest priority.

Thus, efforts to reverse affirmative action met with hysteria in the realm of public health and from some in the medical community as well. Professor Jack Geiger of the City University of New York Medical School published an essay in the September 1998 issue of the *American Journal of Public Health* titled "Ethnic Cleansing in the Groves of Academe." "These reversals are merely the leading edge of a potential public health disaster," he wrote. A public health disaster? Only if there is nothing more important to Americans about their doctors than race.

According to a 1994 Harris poll for the Commonwealth Fund called "Health Care Services and Minority Groups," race does not appear to play a role in

patients' attitudes about their doctors. When asked to cite the "things that influence your choice of doctor," the physician's "nationality/race/ethnicity" ranked twelfth out of thirteen possible options. Just 5 percent of whites and 12 percent of minorities said it was important (a greater portion of Asians, 28 percent, rated race/ethnicity as important, probably due to the language barrier). Still, over 60 percent of white, black, and Hispanic respondents said they did not consider the doctor's ability to speak their language as particularly relevant to their choice of doctor.

For the entire group of 4,000 respondents, such factors as ease of getting an appointment, the convenience of office location, and the doctor's reputation were most influential, cited by about two-thirds of respondents. When respondents who expressed dissatisfaction with their regular doctors were asked for details, only Asians claimed that race or ethnicity was the problem (and the percentage was small, 8 percent of all Asian respondents). Among the small subset of the entire sample who said they "did not feel welcome" at their doctors' offices, a mere 2 percent attributed the discomfort to racial or ethnic differences.

The main complaint of almost all groups was "failure to spend enough time with me." And of those who were dissatisfied enough actually to change doctors, only 3 percent of Asians and 2 percent of blacks did so on the basis of the physicians' race or ethnicity. The most common complaints were "lack of communication," "didn't like him or her," "couldn't diagnose problem," or "didn't trust his or her judgment." Not one person polled said that he felt limited in his options for care because of racial or ethnic discrimination.

The race factor surfaced more prominently in a smaller survey sponsored by Morehouse College of Medicine in Atlanta and published in 1999. Twenty-eight percent of the 215 African-Americans surveyed "considered it important that their doctor be of the same ethnic group as themselves." This correlated closely with the 27 percent of black respondents who did, in fact, have a black doctor. Only one in ten whites of this nationally representative sample expressed a preference for a white doctor, though the vast majority had one.

Do minority patients have better outcomes with minority doctors? There is little evidence that I could find. What about the qualifications of minority physicians? On average, they have lower grades, lower board scores, drop out more often from medical school, and have a higher failure rate on boards. Obviously, the question is not how to get more minorities into underserved areas, it is how to get more good doctors into bad neighborhoods. We can work toward that with loan forgiveness, rent rebates, higher pay, and other incentive programs. There are already many efforts to reach out to introduce high school and college students and minorities to medically related courses. Such initiatives are under way through the Robert Wood Johnson Foundation, the American Association of Medical Colleges, the American Medical Association, and others.

No matter who treats our nation's poor and minority patients, the fact is that they tend to have multiple, chronic medical conditions and are often clinically complicated. They need the best doctors they can get, regardless of race. To be sure, not enough doctors choose to work in rural communities and poor, inner-city neighborhoods. Lowering standards for admission to medical school is not the remedy for that shortage, though. As far as patient preferences are concerned, again it would make more sense to create mechanisms that ensure patient choice.

So, this is Critical Medical Theory. We now have postmodern theories of disease, wherein the ideal of personal responsibility for health is overtaken by the concept that oppression will inevitably undermine it. We have racial preferences in medical schools based on the unfounded notion that doctors are biased against minority patients. Medicine, I'm afraid, will be the next institution beset by political correctness.

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Pedagogical Advocacy

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Although I am affiliated with Harvard's Graduate School of Education, that is usually not enough to redeem me in the eyes of scholars in the arts and sciences or in other professional schools, at Harvard, as well as at other universities. Indeed, education schools have always been at the low end of the academic totem pole because their courses, their research, and their ideas on pedagogy and curriculum have not been viewed as warranting intellectual respect. Regrettably, there is good reason for this judgment.

Education schools have not tended to promote pedagogical ideas that result in the qualities that college faculty have traditionally sought in their students: disciplined study habits, a knowledge base that enables them to study the subject matter of their courses in its mature form, a capacity for analytical thinking, and the ability to write clearly and cogently about the substance of their courses. That many students enter college with these qualities is usually not a result of the training their teachers received in schools of education. Nor do education schools have a track record of promoting pedagogical ideas that have worked, or worked well, for those students who do not go on to postsecondary education. But today, in a stunning perversion of their primary mission, education schools now promote pedagogical and curricular ideas—whether associated with a multicultural approach or a constructivist approach—