**“PHYSICIAN PRIVACY” UNABRIDGED: HOW PRESCRIPTION
DATA-MINING CATALYZED A DEBATE ON COMPETING
VISIONS OF THE MEDICAL PROFESSION**

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the Faculty of Graduate Studies and Research
in Partial Fulfillment of the requirements for the degree

Masters of Arts

by

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Abstract

The following analysis focuses on the social status of the medical profession and medical expertise as one dimension through which one can build an understanding of the current challenges faced by Canadian public health care system. The analysis applies a theoretical approach rooted in Michel Foucault's writings on power and knowledge to describe the context of the recent emergence of "physician privacy" as a contested notion in medical communities across North America. Physician discourses regarding the protection of their prescription-linked information comprise the object of study as a manifestation of a complex series of power relations between physicians and the pharmaceutical industry. In describing such discourses and the power relations with which they are implicated, the analysis demonstrates how physician privacy acts as a vehicle for affirming and redefining the medical profession's stature in society. It also demonstrates how the materialization of different visions of health care delivery, and the physician's role in such models, ultimately hinge on the legal, political and social privileges enabled by shifts in information-control – whether favorable or counter to "physician privacy".

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Cet ouvrage est dédié à la mémoire de mon frère Enrique Palad.

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Chapter 1: A symptom of something larger

In this thesis, I examine an isolated conflict between physician communities and their claim to a privacy right against pharmaceutical data-mining companies. Such companies collect valuable information about the prescribing habits of doctors from pharmacy databases and sell it to clients in the public sector, in the media, and primarily to private sector drug manufacturers for profiling and drug-detailing purposes. This conflict embodies the current challenges faced by North American health care systems, which continuously struggle with the realities of decreasing financial sustainability, as well as declining public confidence in medicine and service provision.

My aim is to show how “privacy” is used as an argumentative space to assert, to challenge or to redefine the status of doctors in health care delivery. Beneath “privacy” lies a complex network of tensions between physicians and the pharmaceutical industry that is rooted in the social importance of knowledge and expertise.

My project uncovers competing discursive formations of entitlement in the language used to discuss these tensions. It is not concerned with the semantic debates regarding the meaning of “physician privacy.” Its focus is on the core dimensions of the context from which this sensitivity towards privacy intrusion has emerged. In doing so, the analysis clarifies the broader social and political stakes associated with the outcome – that is, either a reinforced or weakened notion of physician privacy. Rather than dismissing the conflict as incidental, isolated and unique to doctors, I display the underlying public policy implications and concerns that other professions may experience.

This opening chapter describes an intellectual and social landscape in modern medicine in which physician discourses about “privacy” have emerged. It explores the

value of prescription information as perceived by data-mining companies, but also explores socio-political factors that explain why control of this information is so important to doctors. These include the decline of public trust in medical practice and expertise expressed in mainstream literature, as well as the loosely constructed conceptions of “privacy” as developed by theorists, legislators and Canadian courts – particularly in the context of health care. In highlighting these factors, the chapter establishes research questions about power and the methodology needed to analyze the phenomenon of emerging physician discourses about privacy.

JUST HOW IMPORTANT IS PHYSICIAN-LINKED PRESCRIPTION DATA?

A key event that summarizes the issue’s context is the *Maheu v. IMS Health Canada*¹ Federal Court of Appeal case, which illustrates the degree to which physician-linked prescription information is sought by data-mining companies. In 2001, Ronald Maheu, President of Pharma Communications – based in Markham, Ontario – submitted a complaint to the federal Privacy Commissioner (then George Radwanski) claiming that IMS Health Canada – based in Pointe-Claire, Quebec – engaged in information-collection practices that breach the *Personal Information Protection and Electronic Documents Act* (PIPEDA). This is Canada’s most recently enacted federal privacy legislation which specifically targets the private sector. Maheu claimed that information about physicians was being extracted from prescriptions and collected by IMS without their knowledge or consent. Pharma Communications, in contrast, claimed to have sought knowledge and consent from doctors in their practices.

According to Radwanski’s subsequent report, the information included doctors’ names, identification numbers, telephone numbers and prescribing details. The data,

however, was not deemed “personal information” about the physician under the legislation. Maheu’s complaint was therefore dismissed because such information was considered a “work product” of patient-physician interactions (*Maheu*, 2003 at par. 6). According to the Commissioner, a prescription “discloses little or nothing about the physician as an individual” adding that prescription information is “not normally treated as personal information about himself or herself by the prescribing physician” (Radwanski, 2001). If such information were deemed personal, the definition would be too broad and include various work products,² thus prohibiting entire classes of legitimate market reporting practices.

In response to the Commissioner’s findings, Maheu applied to the Federal Court of Canada on November 2, 2001 for a motion to strike. In determining whether the Commissioner’s dismissal was justified, Prothonotary Hargrave found that:

...it objectively appears that there is reason to believe that the Applicant [Maheu] is using the Act for a collateral and improper purpose, rather than for the purpose set out in section 3 of the Act. As I have indicated the Act is designed to regulate the collection, use and disclosure of personal information generated in commercial activities. Here the Applicant’s own personal information is not at issue in any way.³

The Court focused on the probability that Maheu was using PIPEDA to gain a commercial advantage over IMS, and ordered Maheu to post security for costs amounting to \$12,000.⁴

A closer look at IMS Health’s business further illustrates the value of prescription information. Ludwig Wilhelm Frohlich founded Intercontinental Marketing Services in 1954 and subsequent to numerous mergers and acquisitions, the company now considers itself “the leading provider of business intelligence and strategic consulting services for the pharmaceutical and healthcare industries.”⁵ Present in over one hundred countries,

with its corporate headquarters in Norwalk, Connecticut, it collects raw prescription data that is extracted from approximately 225,000 supplier sites across these countries.⁶ This data tracks nearly seventy-five percent of sales transactions involving over one million products manufactured by more than three thousand pharmaceutical firms.⁷ Some of its products are designed for pharmacies in their database management activities, such as the Electronic-Point-of-Sale systems which extract the data needed to build customized analyses for the drug manufacturing industry.⁸

Products for drug manufacturers include *PharmaTrend* that measures “the impact of promotional campaigns” as well as the *Therapy Dynamics* and *Therapy Forecaster* applications, which provide access to longitudinal data to interpret “what the market is saying about drug switching activity and utilization patterns.”⁹ Other products are used to develop a more tailored understanding of physicians, like the *Segmentation* tool which groups and subdivides physicians according to behavioural attributes. Similarly, IMS’ *Territorial Sales Analysis* (TSA) reporting tool compares the sales of a customer’s product with a competitor’s product through all distribution retail and non-retails channels.¹⁰

The Canadian IMS website describes products that provide information on regulatory environments, such as the *Provincial Reimbursement Advisor* (PRA) service, a quarterly report that outlines key reimbursement issues faced by the industry. The company’s annual *PharmaFocus* briefing informs participants of long-term market trends and updates on new and recently amended federal and provincial policies in health care.¹¹

This abundance of services serves a *clientèle* of pharmaceutical and biotech firms, financial analysts, public and private medical research laboratories, government

departments and regulatory agencies. In 2006, the company reported an estimated \$2.0 billion revenue.¹² The virtually uncontested and multifaceted presence of IMS in the health care sector is attributable to the fact that it offers something for everyone: not only does it provide software for pharmacies, but training resources for Canadian pharmacists and medical students. It also contributes its data to medical research initiatives designed to assess the health of Canadian populations.¹³ From the public interest point of view, IMS data can inform the public on the overuse of Ritalin in children – and trigger the development of guidelines that limit its prescription to specific symptoms in children.¹⁴ From a commercial interest perspective, IMS data can inform a drug manufacturer that an increased consumer awareness of Generalized Anxiety Disorder (GAD) corresponds to rising sales of a certain antidepressant XYZ, which was initially restricted to the treatment of specific forms of depression. The data, its collection, its dissemination and its sale therefore play an important part in crystallizing medical realities about conditions like GAD.¹⁵

By extension, IMS Health is arguably at the centre of constructive processes in “health” and “well-being”. In establishing its market control over such data, IMS Health has become a powerful player in health care. According to its website, IMS is:

...an essential partner in helping stakeholders understand, shape and advance health care. We observe, measure and report on what actually is happening in the world of healthcare, enabling us to work with health professionals to determine what should be happening and to help make it happen.¹⁶

The business of IMS Health and the desirability of the data by numerous stakeholders are illustrated in an advertisement featured in *Product Management Today* (see Appendix A). The company is influential due to its business, yet its business is a function of privacy: it

is crucial that “privacy” or “information access” are defined in a way that enables the collection, manipulation and consumption of physician-linked prescription information.

Though the *Maheu* case was a battle over market control of prescription data, it drew attention to a sphere of activity which was unknown to many physicians. They were not aware of such companies, their practices or their role in health care provision – nor did they did know that their prescription information was necessarily “up for grabs” to the extent seen in the products and services offered by IMS Health. Thus a vulnerability comes into view regarding the ripple-effects that may result from this perceived loss of control over their prescription information, as well as the market mobilization surrounding this information as a highly sought commodity. This vulnerability takes added shape given the social circumstances of doctors, as practitioners of a profession that is struggling with declining public trust.

PUBLIC QUESTIONING MEDICINE, MEDICINE QUESTIONING ITSELF

Throughout much of the literature on professions and professionalization, a common theme is the importance of control in the emergence and maintenance of a profession. This element pervades many definitions including that of Eliot Friedson (1970) who sees a *profession* as “distinct from other occupations in that it has been given the right to control its own work” (p. 71). For these reasons, practicing medicine as a career became a means of “substantial economic-well-being” – as an alternative to management structures that developed out of the Industrial Revolution (Kritzer, 1999: 719).

A more sociological conception offered by Herbert Kritzer (1999) defines a profession based on its enjoyment of a recognized exclusivity through licensing (or unionization) – and based on its application of abstract knowledge-base expertise. More

relevant to the medical profession is its underlying association with altruism, the autonomy doctors enjoy in their relationship with their clients (patients) as well as the autonomy they enjoy from external regulation given established peer-review mechanisms. As such, according to the Kritzer, such professions “have regularly asserted claims of independence that other occupational groups have never successfully advanced” (p. 717).¹⁷

Control is at the base of this gain in socio-political power, but it is also at the base of the profession’s subsequent decline. In his discussion on post-professionalism, Kritzer (1999) identifies key factors that contribute to a loss of control over one’s profession: its loss of exclusivity, growing segmentation in the application of its abstract knowledge and the emergence of technology as a means of accessing information (p. 720). The autonomy of doctors is gradually being eroded by institutional, bureaucratic and commercial interfaces that have arguably warped the doctor-patient relationship (Kilborn, 1997 and Stolberg, 1998). Newer therapeutic roles are emerging, such as those of the pharmacist and nurse practitioner, which arguably cut into the exclusive command of medical expertise. Kritzer (1999) also notes a broader democratization of medical knowledge through the Internet:

Consumers turn to information sources unavailable in the mid 1990s to obtain information that once was the virtual preserve of the professional service provider, and they can access that information without having to first learn a complex system of categorization of the type customarily used to organize specialized information. In addition, consumers can connect with other consumers to share experiences and information and to provide support to one another (p. 715).

Whereas a “competence gap” used to justify the power asymmetry between the physician and the patient, shifts in technology and information access are shaping client demands for greater physician accountability, greater suspicion of medical expertise and science –

towards is described by some as the “revolt of the client” against physicians’ legitimacy (Haug, 1976: 83).

The manifestations of this shift are many: increases in malpractice suits (Haug, 1976: 86) as well as an overall increase in public awareness of medical errors and inconsistencies in clinical research (Schlesinger, 2002: 193). The trends are explored in a number of studies, an example is the survey entitled *Health Care in Canada: a National Survey of Health Care Providers and Users* which was conducted in 2000 by a collaboration of pharmaceutical companies, market research firms as well as medical associations. Among its findings the survey found that “[t]he majority of Canadian health care providers and users continues to express declining confidence in the health care system, with 51% of the public, 59% of doctors, 58% of nurses and 45% of pharmacists reporting declining confidence” (p.12). Not only are doubts expressed by the public but by health care professionals as well, regarding the field of expertise and the operation of the health care system as a whole.¹⁸

Mainstream media provides another set of indicators as to this decline in status. Quick online Google searches of news headlines yield a mix articles about unethical or neglectful medical practices, such as Deborah Kotz’ article in the *Boston Globe* entitled “Doctors feeding addicts’ habits with painkillers: all too common” (2011), Rita Rubin’s article in *USA Today* entitled “Study: Doctors don’t always report colleagues, errors” (2007), Gina Kolata’s article in the *New York Times* entitled “Study Says Chatty Doctors Forget Patients” (2007) and lastly, Alex Berenson and Andrew Pollack’s article in the *International Herald Tribune* entitled “Doctors paid millions by Amgen and Johnson & Johnson to push anemia drugs” (2007). Other headlines feature more serious issues and

extreme cases such as David Muir and Peter Martinez's piece "Drug Addicted Doctors Create Patient Risk" (2009) and Emily Walker's piece "Most Doctors Will Face Malpractice Suit, AMA [American Medical Association] Says" (2010) – both published on *ABC News Online*. Varying degrees of sensationalism pervade these mainstream depictions of uncertainty as to what doctors know and practice in their daily profession. Such depictions, in some cases, acquire their headline status within the context of a catalyzing event or a catastrophe. Examples include Sheri Fink's article in the *New York Times* ("The Deadly Choices at Memorial") on Dr. Anna Pou, a physician working for the Memorial Medical Center in New Orleans, who was arrested on homicide charges for lethally injecting patients during evacuation efforts in response to Hurricane Katrina in 2005. The mishandling of epidemics and pandemics, such as SARS and H1N1 are also key contexts for critiques of public health administration.¹⁹

Physicians are responding to this shifting environment in various ways. One major response has been to target the pharmaceutical industry as an interfering force in the literature that expresses concern regarding the industry's influence over health care systems. Although it acknowledges the industry's vast contributions towards research funding and physician and patient education programs, the literature ultimately addresses the industry's political power – and the effects of such power – as a dominant lobby group that contributes large sums of money to electoral platforms that are conducive to its ideal market environment (Haroutunian, 2005; Drinkard, 2005).²⁰ Other authors critique the effects of this dynamic. In *The Truth About the Drug Companies*, Marcia Angell describes the United States as an "overmedicated society" characterized by a "highly drug-intensive style of medical practice" and a lack of alternative treatment options for

patients suffering from chronic diseases (Angell, 2004: 153). In *Selling Sickness* (2005) Ray Moynihan and Alan Cassels similarly criticize the industry's drive to find an "ill for every pill." Jerome Kassirer, former editor-in-chief of the *New England Journal of Medicine*, provides another comprehensive analysis of the commercialization of medicine, through the personal anecdotes of medical practitioners, in his book *On the Take: How Medicine's Complicity with Big Business Can Endanger Your Health* (2005). Inevitably the goal of this response is to take greater ownership of this commentary with the development of a public relations specialization, so as to diffuse public scrutiny, restore trust and manage the profession's mainstream image.²¹

Only recently has medical literature explored specific questions regarding physician-linked information and privacy as associated causes of the profession's decline. As Marc Lee (1998) explains, "[i]nformation is a fundamental commodity in an economy increasingly based on the use and application of knowledge." Personal health information, he adds, "may be one of the most valuable of all, with large sums of money at stake in its commercial use" (p. 3). Where authors like Angell (2004), Kassirer (2005) and Law (2006) have gone beyond the usual themes of doctor-patient confidentiality, is their exploration of other information-related causes of the skewed political and economic power exercised by the pharmaceutical industry. An example is the growing dominance of commercial authorship for clinical information about usage of pharmaceutical products, as well as meta-knowledge regarding treatment options and diagnostic approaches. These analyses acknowledge that *control* was central to the medical profession's once thriving status, and acknowledge that *control* may have been the basis for subsequent decades of

declining public doubt, and hence, it could therefore be the element through which the profession can save itself as well.

Allusions to these control issues in literature are evidence that the profession is aligning itself towards a privacy cause given that “privacy” is now largely understood as an information-control issue. By examining philosophical, legislative and judicial writings about privacy, specifically its narrowing development towards information-control, I can locate the design “physician privacy” in terms of how it was carved out from the general notion of privacy, as well as the fundamental conceptual difficulties associated with this tailoring process.

THE ELUSIVENESS OF PRIVACY AND “TEMPLATE” PRIVACY

In searching for an understanding of privacy that corresponds best to the circumstances of physicians facing data-mining practices, I found several layers of discussion regarding the general and legal meanings of privacy, its historical origins, the social and economic costs of its infringement, how it differs from the related concepts of confidentiality, secrecy and autonomy, its status as a right and broader philosophical debates on how the concept should be discussed in the first place. Despite the varied mix of perspectives, a few key observations can be drawn from this body of literature.

Privacy discourse is marked by two significant points in its history. The first point is commonly noted as Samuel D. Warren and Louis D. Brandeis’ article in the *Harvard Law Review* (1890). It is the earliest substantial discussion of a right to privacy or “the right to be let alone”, emerging alongside the threats to an “inviolable personality” posed by “recent inventions and business methods” (p. 195). The second point is the narrowing or branching-out towards informational privacy catalyzed by Alan Westin’s

work. Privacy, according to Westin (1967), “is the right of the individual to control the information about himself that he chooses to share with others, how much he gives, when he gives it, and so on” (pp. 32-39). As a whole, privacy literature consistently acknowledges the notion’s fundamental roots as depicted by Warren and Brandeis – this aspect is never lost. Yet it also acknowledges a number of realities warranting the specific direction taken by Westin to focus on personal information flows and one’s ability to control them.

In between and after these two points are numerous attempts at emphasizing different aspects of privacy. Authors like Milton R. Konvitz (1966), for instance, emphasize the protection of personal space or the “inner man” (p. 279), thus elaborating on Warren and Brandeis’ notion of “inviolable personality” (see also Edward J. Bloustein, 1964). Each author has a way of raising the predominant elements of space and control to define a private realm from a public realm – and often explores questions regarding privacy’s status as a positive right (*freedom to*) or a negative right (*freedom from*). Common variations include the right to act, or the right to decide, without interference from government or others (see Patricia Boling, 1996: 20). Deckle McLean’s work (1995) provides a comprehensive overview of privacy’s many public-private nuances:

One is privacy as access control: controlling one’s personal boundaries and the release of one’s secrets; not having one’s mask stripped away. Another is privacy as room to grow: cultivating interior processes for understanding, enrichment, and integration of character and personality; and sharing the same with trusted others. A third is privacy as a safety valve: resting and recuperating from the public arena. A fourth is privacy as respect for the individual: insisting that one is more than a cipher and respecting others for being more than ciphers (p. 52).

McLean summarizes what general privacy can embody depending on its application in real-world contexts. Authors grappling with informational privacy similarly supplement

Westin's control model with their own nuances. For Ruth Gavison (1980), privacy is an issue of accessibility with regards to "what others know about us, the extent to which they have physical access to us, and the extent to which we are the subject of the attention of others" (p. 421). Sandra Petronio's (2002) definition refers to accessibility in a related manner, by specifically discussing the importance of boundaries to determine ownership and control over one's personal information (see also Irwin Altman, 1975).²²

The emergence of these understandings of privacy vary according to the perceived "enemy" at different points in time, and in different situational circumstances: the state, innovative technologies, the private sector, the mass media and even the public – with the recent proliferation of social networking sites like Facebook that facilitate a sense of personal sharing and voyeurship. In any case, the result seems to be an accepted chaos to the discussion as languages proliferate around these select elements of space and control, with each language offering different insights about privacy.

The elusiveness of privacy is also visible in Canadian jurisprudence, largely due to the fact that privacy is not conceived as an absolute right – as it must weigh in against other values such as transparency and national security. Justice Dickson in *Hunter v. Southam*, [1984] 2 S.C.R. 145 notes that in privacy-oriented cases:

...an assessment must be made as to whether in a particular situation the public's interest in being left alone by government must give way to the government's interest in intruding on the individual's privacy in order to advance its goals, notably those of law enforcement (par. 25).

The elusiveness of privacy in case law is also explained by the absence of an explicit inclusion in Canada's *Charter of Rights and Freedom*; thus meaningful discussions in cases span across loosely linked themes of personal or corporeal privacy,²³ territorial privacy²⁴ as well as informational privacy.²⁵ The common practice has been for courts to

interpret the *Charter* so as to identify a “reasonable expectation” of privacy in the areas of freedom of conscience, religion, thought, belief and opinion provisions under section 2; the right to life, liberty and security of the person provisions under section 7; the right to be free from unreasonable search and seizure provisions under section 8; the right to counsel, in private, under section 10; and finally sections 11 and 13 which pertain to the right against self-incrimination (Charnetski *et al.*, 2001: 24).²⁶

Due to the multiple contexts in which privacy issues emerge, this notion has been incrementally defined relative to the protection of these norms “arising out of considerations such as property, bodily integrity, decisional autonomy, and confidentiality” (Austin, 2006: 186). The result is a fragmented body of thought that stems from the incidental and *post facto* nature of case law. This is particularly noticeable in the emergence of a privacy tort in common law jurisdictions to *fill in the gaps* of the current legal framework.²⁷

Overall, this elusiveness is compounded by “template privacy” – or the structured and normalized character of privacy legislation. This trait characterizes Canada’s most recently enacted federal privacy legislation, the *Personal Information Protection and Electronic Documents Act* (PIPEDA), which is a product of its history and the imminent future of privacy protections. It is an improvement over the earlier *Privacy Act* in that it balances the right to privacy against the need of organizations, beyond the public sector, to collect and use personal information. This scope of protection is enabled by its definition of “personal information” as “information about an identifiable individual, excluding the name, title or business address or telephone number of an employee of an organization” under section 2(2). The definition is open to broader interpretation given

that it is not delineated by a series of sub-categories of what is deemed “personal information”²⁸ as seen with the definition provided in the *Privacy Act*.

PIPEDA also includes a set of “fair information” principles that takes its roots in the *Privacy Act*, the *Canadian Standards Association Model Code for the Protection of Personal Information* (as an extension of the *OECD Guidelines on the Protection of Privacy and Transborder Flows of Personal Data*) – as well as the European Union Data Protection Directive (95/36/EC) (Phillips, 2000). These principles include: accountability, identifying purposes, consent, limiting collection, limiting use, disclosure, retention, accuracy, safeguards, openness, individual access and provide recourse. For Austin (2006), these principles “still represent the international consensus regarding data protection and are considered minimum standards” that can be supplemented by further domestic protections (p. 194).

Throughout this legislative progression, a language grid replicates itself, which delineates *what* it is that is to be officially protected through the definition of “personal information”, and a means component that sets out *how* this *what* is to be officially protected through fair information principles. Furthermore, the grid is replicated in provincial legislation that is deemed “substantially similar” to PIPEDA (Radwanski, 2002b: 2):²⁹ Quebec’s *Act Respecting the Protection of Personal Information in the Private Sector* in 1993, British Columbia’s *Personal Information Protection Act* in 2002 and Alberta’s legislation (of same name) in 2004.³⁰

Critiques have inevitably surfaced following PIPEDA’s three-year phase-in period, triggered by events such as the sudden resignation and replacement of George Radwanski as Commissioner and the constitutional challenge launched by the Attorney

General of Quebec in 2003, claiming the legislation impinges upon provincial jurisdiction.³¹ Among the consequences of PIPEDA's design, is the development of personal health information protection legislation in provinces such as Alberta, Ontario, Manitoba and Saskatchewan – which addresses the relationships between actors in health care involved with information transactions – with a structure similar to the federal “template”.³²

This recent trend in health information legislation development, according to Joy Pritts (2002), is driven by the reality that professional ethics guidelines, codes and policies are not adequate means of addressing the complex concerns associated with the handling of personal information (p. 327). There are clearly defined principles governing the sale and use of physician prescription data by the Canadian Medical Association policies (see Appendix B: *Statement of Principles: The Sale and Use of Data on Individual Physicians' Prescribing*), but whether these standards “bear normative force at law” ultimately depends on the intended purpose of legislators and courts' decision-making approaches (Campbell and Glass, 2001: 489). Health information laws therefore address a particular legal void. Despite their broad language and the adjustment process they undergo through courts and ombudsmen, however, legislation by nature lacks regard for the “evolving nature of practice” in specialized fields such as medicine.³³

The elusiveness of “privacy” pervades black-letter law just as it pervades philosophical discussions on the notion. In highlighting a number of important nuances, case law deals with privacy issues in a reactive case-by-case manner, thus comprising a fragmented body of interpretation. Case law, in turn, falls upon legislation as the benchmark for drawing out such nuances – though the generic template of privacy

legislation lacks the specificity to appeal to an uncharted expectation of privacy. These regulatory gaps that surface between the over-specificity in case law, resulting from the concept's malleability, and the under-specificity required for legislation to be flexible, is what physicians seem to be reacting to in their privacy discourses. Their working conception of privacy appeals to a broader understanding of control based on the power dynamic it enables, and nowhere is this better explored than in surveillance literature.

PRIVACY AND SURVEILLANCE

A subset of authors have commented on the difficulties of developing a substantive definition, suggesting that a study of underlying contexts yields a more complete understanding of privacy. Barrington Moore Jr. (1984) points to the study of a society's cultural environment and its value system, for instance, while Elizabeth Neill's (2001) suggested approach is to seek out the "ideology of entitlement" to a privacy right:

Discrepancies in the literature on privacy cannot be resolved without first establishing a clear theory of our ideology of entitlement; for that ideology underlies the existence of our right to privacy, and the complexity of the ideology underlies our confusion about that right (p. 5).

This view arguably calls for a search for the discursive formation of patterns in the language of entitlement. Helen Nissenbaum (2004) similarly proposes an approach that evaluates "contextual integrity" to better depict the complex nature of privacy issues relative to fast-evolving information technologies. The approach aims to attach "adequate protection for privacy to norms of specific contexts, demanding that information gathering and dissemination be appropriate to that context and obey the governing norms of distribution within it" (p. 119). It calls for the study of a "far more complex domain of social spheres" beyond the presumed public-private divides upon which classic theories of privacy were developed (p. 124).

For the project at hand, physicians appeal to informational privacy, in that they seek greater controls over their personal prescription data from pharmacies and pharmaceutical data-mining companies. In delving into complex social landscapes to explain systems of social control, surveillance literature offers an analytical language that can facilitate a nuanced understanding of the context against which physicians develop their language of entitlement. According to David Lyon (2001), surveillance is “any collection and processing of personal data, whether identifiable or not, for the purposes of influencing or managing those whose data have been garnered” (p. 2). Although the subject matter is clearly data-centered, authors typically depict a complex reality and the ways in which information flows (and their configuration) underlie its emergence. The literature is critical of government practices, though in some cases it is more concerned with private sector practices as well. Amitai Etzioni’s *The Limits of Privacy* (1999) argues from the perspective that private sector abuses tend to go unnoticed (p. 130). For Lyon (2001), the abuses arise due to unfettered commodification: “personal data has been commodified on a massive scale and trade in such details appears in many ways to be out of control” (p. 129). Gary Marx (2001) similarly warns of the unchecked nature of private sector information-collection practices, due to the government’s preoccupation with its own practices, or an inability to regulate the private sector in a sufficient manner.

Though the literature is obviously concerned with privacy, its defining nuance is its assumption that data protection enables privacy. According to David Flaherty (1989) data protection is “at present the most critical component of privacy protection, because of the ongoing automation of data bases” (p. xiv). The battle of choice for Flaherty and others is one against electronic surveillance, its motivations and the ways in which it

changes conceptions of personal information and privacy. Of interest is John Wicklein's (1979) discussion of extreme consequences resulting from loosely regulated surveillance systems, particularly those developed in the private sector:

By shaping and censoring what is seen, read, and heard, a corporation that has a monopoly on the system and its content might be able, in time, to shape the view of the public and of government officials to its vision of what the world is and what it should be (p. 10).

Not only is there a dependence in sectors where such a monopoly establishes itself, there is also an associated risk of manufactured realities aligned with the interests of the surveillance system's author and its clients. Authors have studied this phenomenon in various fields such as the insurance industry (Ericson, Doyle and Barry, 2003), the credit industry (von Stein and Ziegler, 1984), as well as policing and border security (Marx, 2005). Similar analyses of surveillance in the medical field are lacking despite ample academic depictions of indicators that an information monopoly is developing.³⁴

Surveillance literature links privacy to social configurations that result from shifts in control over personal information. Important in the literature, for my purposes, is David Flaherty's (1989) view that "surveillance can be good or bad, depending on who does it, why it is being done, and how it is carried out" (p. 12). Where there is an alleged privacy infringement, that is, the boundary-crossing that occurs when prescription data is mined without a doctor's consent, and underlying it is a pharmaceutical surveillance system, there will be discourses that proliferate as to why this system is necessarily a "bad" or "good" thing for health care. These discourses attach a particular meaning to the use of privacy in this context, and help us identify the conflicting realities – or social configurations – surrounding the control over prescription data.

Privacy literature, in the end, includes sources that focus on the core conceptual and legal traits of a right to privacy, and its implications for governance, while others debate the value of privacy from an economics and governance perspective (Posner, 1981). Given a generally-accepted value “privacy”, sources of greater pertinence to my study are those that resort to contexts to illustrate a more global value of privacy.

Surveillance literature is among these sources by proposing that privacy is, at least in part, a product of a given system of socio-political control fuelled and enabled by information control. The literature inevitably points to the importance of using theories of power and knowledge in data-protection contexts, such as the analysis of data-mining and physician privacy. David Brin (1998) anticipates in *Transparent Society* that “a key element in the coming years will not be the extent of information flow (or vision, or even surveillance) as much as the degree of powerlessness that people may feel at any moment, in any given situation” (p. 157).³⁵ The literature has taken the element of control developed by Alan Westin and others, and examined the extent to which control can be successfully achieved by an identifiable system and the extent to which its control is all-encompassing in different contexts – rendering “privacy” an accessible argumentative space for a number of personal and professional circumstances.

THEORY: EXPERTISE, KNOWLEDGE AND POWER

My theoretical approach seeks to explore the interplays between expertise, knowledge and power as applied to the emergence of classical professions (i.e. law, architecture and medicine). As mentioned beforehand, *control* is central to the (de-)construction of expertise alongside the socio-political status of the medical profession (Esquith, 1987: 244).³⁶ Furthermore, authority stems from the ability of expert knowledge “to influence

those who have accepted its certainty” (Sassower, 1993: 66) or those who are willing to invest their hope in its certainty. Thus doctors themselves depend on the patient’s desire for certainty to sustain their position of authority.

To understand how the profession’s inherent vulnerabilities are compounded (or even exacerbated) by data-mining and pharmaceutical market surveillance, I turn to Michel Foucault’s writings on knowledge and power. They provide the analytical language needed to bridge privacy concerns to their underlying power-knowledge effects. In *Subject and Power*, Foucault (1981) describes this tension as “an opposition to the effects of power linked with knowledge, competence, and qualification – struggles against the privileges of knowledge” and “an opposition against secrecy, deformation and mystifying representations imposed on people” (p. 331). To be able to assert that privacy has become a means of regulating the privileges of knowledge – or to assert that privacy is about power – I adopt Foucault’s preoccupation with discourse, where discourse holds the conquest of a given truth or an interpretation of a reality over another set of truths, and where such a conquest is ultimately supported and fuelled by an accompanying body of knowledge. In a lecture presented to the *Société française de philosophie* in 1969, Foucault elaborates on a perspective with which discourses can be analyzed:

Perhaps it is time to study discourses not only in terms of their expressive value or formal transformations but according to their modes of existence. The modes of circulation, valorization, attribution, and appropriation of discourses vary with each culture and are modified within each. The manner in which they are articulated according to social relationships can be more readily understood, I believe, in the activity of the author function and in its modifications than in the themes or concepts that discourses set in motion.³⁷

I similarly view discourse as a means of exploring modes of existence or “intermediate regions” where one can find overlapping, diverging or colliding versions of a given

reality (Nola, 1998: 15). The region of interest is occupied by doctors and market surveillance companies, each engaged in an opposition to the effects of power linked to knowledge, competence and qualification – as well as an opposition against secrecy, deformation and mystifying representation imposed on doctors. For Foucault, and myself as I demonstrate in this thesis project, these layers of opposition are brought to surface through discourse.

At the same time, Foucault's writings help me identify a comprehensive surveillance system against which opposition manifests itself. His notions of panopticism and discipline, for example, were developed to demonstrate "how bodies of knowledge are inextricably interwoven with techniques of social control" (Gutting, 1989: 6) and may accordingly describe the mechanisms through which physicians are constituted as subjects of an expertise developed by the market surveillance industry. For Foucault (1980a), power relations are capillary, heterogeneous, two-way, dispersed yet interwoven – thus "reaches everywhere and affects everyone" (p. 30). Power is a process that "never ceases its interrogation, its inquisition, its registration of truth: it institutionalizes, professionalizes, and rewards its pursuit" (Foucault, 1980b: 93).

Where Foucault might provide the broad underpinnings of a surveillance system rooted in a power-knowledge conceptual dynamic, Oscar Gandy Jr. (1993) builds on this perspective with his discussion of the "panoptic sort",³⁸ which depicts specific monitoring processes associated with surveillance. An expansion on Foucault's interpretation of panopticism, Gandy maps out the means through which a system "gazes" and builds knowledge about a target subject or group. The sort "operates to increase the precision with which individuals are classified according to their perceived

value in the marketplace and their susceptibility to particular appeals” (Gandy, 1993: 2). Throughout the collection and dissemination of personal information, the sort identifies, classifies and assesses individuals according to their market value.³⁹

Gandy’s work thus expands on Foucault’s emphasis on the productive aspects of power. The added insight of this emphasis however lies in its exploration of how subjects contribute to the dynamic through collaboration or cooperation. It enables an analysis of physician acceptance or desire of the surveillance system in question, in cases where they accept the “rules of a game”, and even depend on the game itself as part of their professional identity.⁴⁰

The theoretical approach to understanding physician privacy, in the context of data-mining, borrows from Foucault to describe the qualities of power relations surrounding the materialization of a particular reality – and the ensuing conflicts that arise from it. Central to this theoretical approach is the role discourse plays in revealing those conflicts, the ideal-type realities that vie to become the norm. Discourse is also vital in depicting a surveillance system that is perceived as intrusive, and the specific processes through which it operates and proliferates. Together, each of these theoretical dimensions builds a connection between privacy and the complex reality whereby its intrusion or protection is warranted.

METHODOLOGY

The following chapter analyzes the usage of privacy in discourse, or specifically *what has been said* about physician privacy and data-mining practices. To perform a discourse analysis, a corpus of government, mainstream, academic, medical-institutional and corporate sources was developed. Each source directly or indirectly addresses the issues

of physician confidentiality, privacy, data-mining or personal information flows in the health care sector. Government sources include parliamentary committee reports, departmental press releases, and reports by organizations such as the Canadian Institutes of Health Research, reports and speeches by federal and provincial privacy (and information) commissioners, as well as publications by the European Union. The bulk of these sources were drawn from Google keyword searches⁴¹ and Department of Justice Canada library catalogue searching. A subset of this category is Canadian jurisprudence, consisting in Federal Court of Appeal cases found using LexisNexis Quicklaw in which elements of the PIPEDA are addressed.

Medical-institutional sources include articles, bulletins and press releases by federal and provincial physician associations such as the Canadian Medical Association as well as the Ontario and Alberta medical associations. The category also includes articles from British and American medical journals like *The Lancet* or the *New England Journal of Medicine*. Such sources were gathered using the online portals of medical associations, online search engines like Google and academic search engines.⁴²

Mainstream sources consist of newspaper articles, television program transcripts and books that provide detailed *exposés* of the pharmaceutical industry's marketing practices. Many of these sources were discovered through word-of-mouth and online searching. Recently-published books on medicine by Marcia Angell (2004), Jamie Reidy (2005), Ray Moynihan and Alan Cassels (2005) and Jackie Law (2006) were found on online retail sites such as Amazon.com and Chapters.indigo.ca. Writers like Gardiner Harris, Sheryl Gay Stolberg and Jeff Garth of the *New York Times* were followed given their specialization in health care, particularly conflict of interest issues.

Academic sources include journal articles that provide an external perspective of medicine, rooted in related scientific research fields or sociology and political science, to discuss health policy and regulatory environments. Examples include the articles by Anthony Segreti *et al.* (2001) in the *Journal of Biopharmaceutical Statistics*, Joy Pritts (2002) in the *Yale Journal of Health Policy, Law and Ethics* and Mary Wiktorowicz (2003) in the *Journal of Health Politics, Policy and Law*.

Lastly, drawn mainly from IMS' Canadian and international websites are corporate sources that include market performance reports, press releases on newly developed information products, articles on marketing approaches, as well as online content on the company's history, *clientèle* and its internal privacy and social responsibility policies. Sector-specific journals like the *Pharmaceutical Executive* and *The Regulation Policy Market Report* also provide insider discussions on marketing approaches.

The corpus was developed to gather a coherent and wide-ranging sample of *what has been said* about physician privacy within the medical community and the pharmaceutical industry. In total, approximately a hundred sources were collected (incrementally) over a period of five years (see Appendix C), with the following breakdown: twenty-six government sources (eight of which are Canadian judicial cases), twenty-two mainstream sources, ten academic sources, thirty-one medical-institutional sources and eleven corporate sources. A large portion of sources are American, which is potentially revealing of the politically-active nature of U.S. physician groups, or a stronger tendency among American media to publicize their efforts. These sources were retained given privacy and prescription data access issues are common to the experiences

of the Canadian health care system and medical practitioners – and the broader social climate of increased skepticism of medical expertise throughout North America.

The range of ideas and perspectives is wide among these categories of sources. A series of questions was developed to guide the reading of each source in order to draw out discourse patterns, specifically the various different “voices” (or types of statements) of doctors and those representing commercial interests. These voices point to aspects of their understanding of privacy, and may occasionally contradict each other when compared. Second and third readings were necessary in order to identify the components of a pharmaceutical surveillance system, physicians’ responses to such mechanisms in terms of their varying levels of resistance, mobilization and compliance to the system. The observations drawn from these readings are the basis from which I draw insights regarding *why* and *how* these privacy discourse patterns arise.

Chapter 3 links the themes of privacy, expertise knowledge and power by using the inventory of statements to build the surveillance system against which doctors claim a right to privacy. Applying concepts used by Foucault (e.g. panopticism, discipline) and Gandy Jr., I open up a complex power dynamic which relates the “local” concerns of data-mining to broader systems of health care policy ideals. In doing so, I clarify the stakes of enforcing a stronger notion of physician privacy.

Chapter 4 explores different modalities of physician resistance, and the regulatory shifts that occur as a result in Canada and the U.S. Its objective is to demonstrate the knowledge-power interplay as continuous and adaptive: it describes the modalities of influence through which the pharmaceutical industry circumvent such displays of resistance and rebound from these shifts. The analysis provides a more complete picture

of power plays (and the ever-changing means to carry them out) so as to achieve the stakes of physician privacy depicted in Chapter 3.

In the end, the reader should be convinced of the complex degree to which the concept of privacy is “loaded” and used as one of several means to establish a particular order in health care. In doing so, I demonstrate how “physician privacy” has itself become an argumentative space through which different visions of the medical profession and health care provision collide, and produce uncharted legal formalizations to regulate the profession’s relationship with the pharmaceutical industry.

Chapter 2: Mapping out privacy discourses

In this chapter, I examine a number of statements about prescription data-mining which either deplore or defend the practice on grounds of its effect(s) on the medical profession and health care systems. From these statements I seek clear patterns in language usage to describe how the profession necessarily sets concepts “in motion” to problematize the data-mining issue, and how the profession distinguishes itself from the profit-centered business. By applying the question grid described in Chapter 1, I analyze the different layers of discussion, as well as the varying degrees to which physicians and the pharmaceutical industry oppose each other. To this end, the question as to whether a source is aimed at a specific audience is perhaps the most important consideration in the analysis.⁴³ It draws attention to (in)congruencies between the different “voices” (types of statements) of doctors and those representing the pharmaceutical industry – though interestingly, all “voices” have something to say on medical expertise, and use medical expertise as a justification paradigm for liberating or restricting information flows. I first examine the patterns that define the discourse of doctors and industry discourse, and then identify the aspects of this expertise paradigm where patterns diverge or converge.

THE DISCOURSE OF DOCTORS

A prevailing theme across physician statements is that “privacy” is rarely defined in an explicit manner. More clearly defined are the points of irritation that catalyze requests for greater privacy protections. Statements typically react to the practice of data-mining, the intrusive practices of pharmaceutical drug sales representatives, or both, linking them to the act of over-stepping the doctor’s practice in an unjustifiable manner.

For the most part, privacy is raised after the fact of its perceived violation. This is particularly noticeable in mainstream sources, where physicians recount how their privacy needs suddenly took form after an awkward encounter with a sales representative⁴⁴ who accidentally revealed the depth of knowledge amassed about their prescription habits. The ways in which these reactions are expressed can be summarized in a non-exhaustive typology of statements.

The first type of statement encompasses presumed ideals about science and “good” medicine, thus portraying a perception of what the profession necessarily does that is unique relative to the involvement of the pharmaceutical industry. The second type of statement, the tailored internal perspective of privacy, illustrates physicians’ attempts to identify organizational policies that delineate the ethical boundaries of data-mining in medicine. The third type of statements are “public hooks” that raise awareness on the wrongful nature of data-mining. This type features a subset of statements that engage the public while articulating how physicians view their own profession.

1. PERVERSION OF “REAL” SCIENCE

One series of statements frequently reiterated in physician discourse on data-mining and privacy alludes to the corruption of medicine as a “real” science (Moynihan and Cassels, 2005: 27). By collecting prescription information in an effort to curb prescribing habits, a professional boundary is crossed. These statements are often nostalgic for the extinct public scientist as the author of “good” medical health research devoid of commercialism.⁴⁵ They carry an ideal of pure medicine in which doctors work freely without having fringe actors, such as sales representatives, impose upon their practice.

This ideal of uncorrupted medical practice is partially illustrated in an article

published in *The Medical Post*, where former President of the Alberta Medical Association, Dr. Steve Chambers, explained that greater privacy protections would give physicians the freedom “to prescribe as they see fit based on clinical indications, their own experience and judgment, use of clinical practice guidelines and use of science from pharmacology teaching programs” (Milne, 2002b: 33). In mainstream newspaper articles, the view is stated more clearly by politicians who take up the physicians’ cause. In Joe Mullin’s (2007) article on the recent movement in American states to propose tighter legislative restrictions on data-mining, Nevada Senator, Joseph Heck, maintains that such restrictions are intended to prevent drug companies from “meddling in doctors’ decision-making.” For Heck, who was originally an osteopathic physician by trade, the problem is the categorization of prescription habits as a means of exerting commercial pressure on physicians’ choices.

This ideal is also manifested in training programs recently developed by medical schools in the U.S. that teach students techniques to debate the validity of pharmaceutical research findings with drug sales representatives. Dr. Ethan Halm, an associate professor of medicine and health policy at Mount Sinai School of Medicine in New York, notes that such programs are intended to “appeal to physicians’ natural scepticism.”⁴⁶

In these examples, physicians acknowledge that they do something in their profession that is qualitatively different from what the industry does, and that such difference ought to be delineated and maintained. For Dr. Chambers, it is a body of “experience and judgment” that ought to be fostered through stronger privacy protections. For Senator Heck, it is a decision-making ability and for Dr. Halm it is “a natural scepticism” developed in training to shield doctors from external influences.

To an extent, these tendencies are similarly observed in academic sources.

Articles and editorials like Martin Tattersall and Ian Kerridge's piece in *The Lancet* (2006) may superficially explore broader philosophical issues such as the commercialization of medical treatment paradigms, though they rarely delve into the enabling factors of this process – such as information control. The profession's vulnerability, in knowledge terms, is seldom admitted openly within the institutional voice of doctors, but more so in their journalistic voice.⁴⁷ Rather, the more academic sources tend to re-assert the nature of doctors: scientists, or users of a “real” science.

2. PRIVACY WITHIN THE MEDICAL COMMUNITY “HUDDLE”

The view that medical expertise is fundamentally different from industry expertise, is reinforced in internal discussions about privacy provisions set out in professional ethics codes and policies. Sullivan (2003), for instance, expresses the concern that unprotected prescription data could threaten the safety of certain doctors, notably those who deal with the prescription of emergency contraception. Zoutman *et al.* (2000) similarly explore how the CMA's *Statement of Principles* (1997) regarding data-mining is contravened by the practices of IMS Health Canada. The *Statement* outlines five principles, all of which are arguably violated by IMS in some way:

Principle 1. Data on individual physicians' prescribing must be compiled, sold or otherwise used in a manner that does not compromise the privacy of patients or physicians; anonymity and confidentiality must be maintained.

Principle 2. Except as authorized by law, physicians must be informed of, and their prior consent obtained for, the compilation of prescribing data that identify them and the sale or other use of such data. The consent obtained must be informed, positive, documented and time-limited. For greater certainty, the right of physicians to consent also includes the right to restrict or to refuse to allow the compilation, sale or other use of identifying information about them.

Principle 3. The primary purpose of compiling data on individual physicians' prescribing and developing profiles must be to provide individual physicians with an educational tool to enhance their prescribing practices and the quality of care provided to patients.

Principle 4. Having compiled and analysed the data on individual prescribers, the compiler must make this information directly available, free of charge, to each individual physician concerned, along with appropriate data for comparison purposes. This information is an educational tool that physicians are encouraged to take advantage of to enhance the care they deliver.

Principle 5. Physicians must be provided with the names of any organizations that have been sold, or otherwise given access to, data about them (CMA, 1997: 1-3).

Not only is prescription information compiled and sold, but data-matching technologies used by market surveillance companies render physician data identifiable – thus violating Principle 1. Nor is Principle 2 fully adhered to given that IMS presumes physician consent unless informed otherwise. It is not clear, the authors add, whether principles 3, 4 and 5 are respected either, as it would appear that IMS compiles the data for the primary purpose of selling it to pharmaceutical companies, while doing very little to raise physician awareness regarding the practice (Zoutman *et al.*, 2000: 1146-1148). Privacy, here, has obvious professional motivations embedded in the black-letter law of medical associations.

In more mainstream sources, motivations are not as clear since the desired form of professional privacy is not defined in an explicit manner. In a *Medical Post* article, former President of the Canadian Medical Association, Dr. Dana Hanson, maintains that:

The CMA and individual physicians I speak with feel physician-specific information is personal and warrants privacy protection. We feel this treatment information is personal information we have not consented anyone to see, let alone sell. It is a problem (in Milne, 2002b: 33).

Physician statements recognize the need for information protections without unpacking underlying justifications (see also Gerace, 2003). How is the information necessarily

personal and why should it warrant protection? The mainstream physician voice is not so much focused on substantiating the uniqueness of prescription data but rather concerned with displaying a certain solidarity among physicians to the broader public.

3. GETTING THE PUBLIC INVOLVED

Other statements provide justifications of physician privacy that engage public opinion. These employ a more prescriptive, moralistic language of “public good” that highlights the potential impacts of data-mining on the health care system and the well-being of patients. Zoutman *et al.* (2004), for example, weigh the clashing interests – maintaining that “[t]he economic interests of those who benefit from the disclosure of patient and physician-linked prescription information should not supersede the right of patients and physicians to have personal information in pharmacy records held in confidence” (p. 816). Milne’s (2002b) interviews with concerned physicians similarly draws a distinction between the “public good” encompassed by the physician’s stance on privacy, and the “narrow band of interests” that seek information access for commercial purposes (p. 33).

At the same time, the finer political and moral considerations that accompany this weighing process are avoided in all physician statements – whether aimed at the public or the professional audience. Rather than exploring these considerations, sources involve the public by depicting the outrageousness of the dynamic between doctors and the industry. They put on display a set of violations felt by doctors as subjects of data-mining. The following provides a subset of statements that characterize these perceived violations.

(A) “IT WAS DONE BEHIND MY BACK”

Data-mining practices were deemed offensive to some physicians given that they were carried out without their knowledge. The sudden awareness that their prescription information was collected and sold, as well as the high level of detail with which their prescribing personalities were constructed, anchor the view that they were deceived. The language used to describe this deceit is suggestive of a broken relationship of trust that was previously shared with industry in an implicit manner.

For Dr. Brad Drexler, an obstetrician in Healdsburg, California, the practice was troublesome because it was “so hidden that neither I nor any of the pharmacists I spoke with knew it occurred” (Whitney, 2006). The statements take aim at the covert nature of the monitoring practice, as though its imperceptibility alone warrants suspicion. Yet they also reveal the realization of vulnerability, or uncertainty rather, of the boundaries that define their professional lives.

Some sources address the overall secrecy surrounding the funding and design of the industry’s marketing practices. In *The Truth About the Drug Companies* (2004), Marcia Angell depicts the industry as a black box that retains money figures, such as breakdowns of research and development expenditure budgets, away from public scrutiny for competitiveness purposes (pp. 38-39; see also Stolberg and Garth, 2006: A22). It is a black box that refuses to display the same level of transparency expected of the physicians it seeks to profile. Jacky Law (2006) adds to this view, arguing that this need for skewed information access renders the industry’s presence within the health care system “immeasurably sneaky” (p. 28).

(B) “I’M AT A DISADVANTAGE – I’M BEING PLAYED”

Related to the expressed sense of deceit are statements that convey the feeling of being relegated to a disadvantaged position within an asymmetrical dynamic *vis à vis* the industry as a result of data-mining practices. Dr. Dick Zoutman’s interview for CBC’s *Disclosure* elaborates on this dynamic:

If you’re sitting there with the pharmaceutical drug rep in your office and you don’t realize that they’ve got this information ... and not being able to see the information to critique it for its accuracy and its validity – you’re at a severe disadvantage.⁴⁸

The statement illustrates the fact that doctors are accustomed to a certain position of power. They express the feeling of “being played” in a game with objectives and rules that are different from what is understood initially. The feeling of being duped is particularly noticeable in accounts of doctors who realized that their prescription habits were being curbed by the marketing practices enabled by data-mining. Dr. John D. Abramson, author of *Overdo\$ed America: The Broken Promise of American Medicine* (2004), admits that he initially considered himself Robin Hood-*esque* when administering free drug samples to his patients that were provided to him by sales representatives. However, he eventually realized that he was prescribing the same drugs for patients who had drug insurance coverage. In providing Dr. Abramson with free drug samples, he inadvertently enabled the expansion of the *clientèle* for the drug in question. “That’s what they wanted,” Abramson adds “[t]hey were playing me like a violin” (Harder, 2005). The account acknowledges that physicians form a game-like understanding of their prescription habits, while revealing a lack of awareness regarding the extent to which they contribute to the effects of data-mining in their own medical practice.

(C) “THIS IS PROBLEM BECAUSE IT’S HAPPENING TO US, OF ALL PEOPLE”

By using common analogies in mainstream accounts, other offensive aspects of data-mining become accessible to the public. An example is the former head of the Ontario Medical Association, Dr. Albert Schumacher, who compared the practice to “having someone do a report card on you and you don’t know you are being tested and you don’t know how you scored” (CBC, 2002). The analogies depict the flagrancy of data-mining, where an esteemed field like medicine is brazenly opened up to a form of scrutiny that is typically experienced by an ordinary person – while simultaneously revealing a bruised professional “ego” as a result of this realization.

This concern with the profession’s social clout is expressed differently by British Columbia-based Dr. Warren Bell, who was offended by drug representatives because they were not genuinely “nice” to him because he was doctor, but because of the business he could bring to their company (Moynihan and Cassels, 2005: 38). No longer is the importance of doctors solely attributable to their expertise, rather, the analysis of their prescription habits has shifted this importance into a realm of commercial considerations.

The seriousness of these statements lies in the fact that physicians are the targets of this practice, when the profession has historically remained insulated from infringements experienced by other professions and social classes. The statements further justify physician privacy on the basis that their expertise is patently distinct from what is seen in other service sectors. One pattern through which this is established is an author’s reference to the Hippocratic Oath. Dr. Leo Cellini’s editorial in the *Canadian Medical Association Journal*, for instance, maintains that “the issue of privacy is perhaps more fundamental to the profession of medicine than to other professions, given the obligations

we accept when we take the Hippocratic Oath” (see “Privacy Policy”, 1999, p. 988).

Mention of the Oath creates a symbolic affirmation of the authority underlying the profession’s right to privacy, despite the fact that the Oath typically emphasizes confidentiality as opposed to a broader understanding of privacy.⁴⁹

The uniqueness of medical practice is expressed differently in articles that emphasize the profession’s fundamental concern with patient well-being. Dr. Zoutman’s disappointment with the decision rendered by former federal Privacy Commissioner George Radwanski, regarding the status of prescription information as a “work product”, illustrates this type of emphasis:

He [the Privacy Commissioner] compared us, the medical profession, in his report, to chefs and to roofers and to mechanics. And all deference to the important value of chefs, roofers and mechanics and the important work they do in our society ...But the relationship between a physician and a patient is very different. I’m able, when I’m dealing in a restaurant or with a roofer or a mechanic [as the customer], to say what I want to do. I’m in a situation of fairly equal power. The physician-patient relationship is very lopsided towards the physician who has a great deal of power over the patient and that has to be acknowledged (CBC, 2002).

The comment says more about the profession’s self-image, and the manner it should be perceived, than the meaning of “privacy”. With stronger moralistic language, others focus more on the effects of data-mining on patients. For former CMA president Dr. Sunil Patel, in plain terms, IMS’ practices are not “in the interest of patient care” and serve “no other purpose than marketing” (Kermode-Scott, 2003b). This concern sets a distinction between doctors who “put their patients’ best interest foremost” and the commercial aims of drug companies (*Concord Monitor*, 2007), thus presuming a dichotomy between private profit and public good that counteracts the industry’s view that private profit necessarily yields public good (Law, 2006: 138). In a subtle manner, the article by Celia Milne (2002a) on the B.C. government’s move to amend the bylaws governing the

College of Pharmacists to prevent pharmacies from selling physician-linked data, illustrates this stand-alone concept of “public good”.

At the time, B.C. Health Minister John MacPhail admitted it was an extraordinary measure but that *the public expected* the government to take action against the practice of buying prescriber information for use in targeting promotions to individual physicians (emphasis added; p. 33).

Other statements, however, illustrate instances where “privacy” hinders “public good”. In the context of patient privacy, Richard Horton’s editorial in *The Lancet* entitled “Striking the right balance privacy and public good” (2006), expresses an aversion to regulatory protections given that they would burden access to personal data needed to generate health research. Here, individual sacrifices of privacy represent a reasonable trade-in for the “greater societal good” of health research (p. 275). Hence, the value system used to justify greater privacy protections wavers according to ideals of efficient health care provision – whether they relate to good health research or sufficiently protected doctors.

(D) “IT’S WAR... IT’S US VERSUS THEM”

The language used in mainstream article titles illustrate the polarisation of interests in privacy discourses. The military-oriented tone is noticeable in Jake Whitney’s article in *The San Francisco Chronicle* (2006), entitled “Pushing Pills: Mining Prescription Records for Fun and Profit – California has become a battle ground in a debate over how Big Pharma’s access to prescription data affects patient care and the price of drugs”; Stolberg and Garth’s article in the *New York Times* (2006) “High-Tech Stealth Being Used To Sway Doctor Prescriptions”; and Kris Hundley’s article in the *St. Petersburg Times* (2007) entitled “Doctor combats pull of drug reps”. The battle-talk is equally present in the titles of sources published by the physician community itself, as seen in the *CMA News* piece (1997) entitled “MDs urged to fight sale of prescribing data”. The title

of Sarah Houlton's article "Drug Info War Heats Up" in the *Pharmaceutical Executive* (2002) similarly demonstrates the industry's acknowledgement of the conflict.

The sources' contents provide further insight on the "us-versus-them" dynamic. In *Big Pharma: Exposing the Global Healthcare Agenda* (2006), Jacky Law refers to the "information war about the nature of health" (p. 229) – a characterization that parallels Stephanie Saul's (2006) view that prescription information is "the most potent weapon in pharmaceutical sales" (Whitney, 2006). The language portrays an "other", an enemy, a cunning adversary, or a well-oiled marketing machine in its relentless pursuit for profits.⁵⁰ In doing so, the language produces a caricaturized gloss over the conflict.

Anthony Hall's (2006) article in *The New Physician* describes how pharmaceutical marketing targets medical students early in their training. When describing drug representatives, as users of the data compiled by surveillance companies, the language sensationalizes the elaborate machinery behind their marketing approaches. Through this language, sales representatives are depicted as *femmebots* or Ken dolls: devoid of emotion or conscience, trained and programmed to sell products using all devices made available to them – including sex appeal. They are "[y]oung, stylish, articulate sales reps who often look like runway models trained by prominent psychologists from top-shelf schools and by color consultants from Macy's, Nordstrom's and Bergdorf Goodman" and can "artfully sidestep questions when profits and clinical data come into conflict" (Hall, 2006).

In the same article, as a rare occurrence among all the sources consulted, Hall's interview with Dr. Patrick Brennan, chief medical officer of the University of Pennsylvania Health System, reveals a limit to this war. He maintains that physicians do

not intend to sever their ties with the industry as a result of its marketing practices. They are instead “trying to have a different sort of relationship that’s based more on *evidence* and *science* and education than on marketing” (emphasis added; Hall, 2006). The statement thus reveals why power relations between the industry and physicians are more complex beyond a mere “war” opposition. It reveals a dynamic in which physicians attempt to define themselves in opposition to the industry, despite the acknowledgement that they are ultimately dependent on the industry in various ways.⁵¹

DIAGNOSIS OF THE ISSUE – AND TREATMENT

Although physician statements rarely provide substantive definitions of privacy, they do offer an understanding of the concept relative to the profession’s objection to pharmaceutical marketing practices. Physicians object through “other-ing” and re-affirmation of their practice as something qualitatively closer to true science – thus unique and indispensable to society. Another component of physician privacy discourse are statements about remedies for a public health care system that is increasingly becoming unsustainable in administration and costs. Statements frame “privacy” as a means of disentangling physicians from the commercialization of medicine, in an aim to restore certain ideals of how the medical field *ought to be*. These normative claims vary by the suggested degree of de-commercialization, some specifically emphasizing the need for stronger protections against the use of prescription information by third parties, while others envision a complete severance from the industry. These remedies will be further discussed in Chapter 4.

Lacking in physician discourses are discussions as to why health information flows are such that the health care system depends on IMS Health products. Few pieces

emphasize the need for public mechanisms that house the data needed to evaluate the system's operation and effectiveness – comprehensively beyond the theme of prescribing habits.⁵² Gloria Galloway's article in the *Globe and Mail* on the findings of the Health Council of Canada's third annual report is a rare expression of this argument. She raises the problem of inconsistent or incomplete information, "[t]here is no way to determine whether governments are making substantial, positive changes to the Canadian health-care system because the information to measure progress is not being collected" (Galloway, 2007: A4). The article, like most, does not explore the possibility that this data void may be the cause of the system's current reliance on industry-collected information. It is more concerned with a narrower set of statistical indicators such as emergency and specialist referral wait times. Even when sources relate the ills of health care provision to a lack of insightful health data, they do not venture into the reasons underlying this particular lack nor the system's dependence on the information and clinical research provided by the pharmaceutical industry. Instead, what is seen across these interpretations of the issue are attempts to initiate and lead the delineation of the profession's role and its relationship with the pharmaceutical industry, in a public sector that is continuously impacted by competing interests. Within industry's discourse on privacy, a similar drive to lead this delineation process is observed.

THE DISCOURSE OF THE INDUSTRY

Similar to physicians' discourse, the discourse of the pharmaceutical industry is not primarily concerned with defining privacy *per se*, but concerned with how privacy can be used to clarify its business. In the case of IMS Health, the statements paint a mixed self-portrait in which IMS Health is *more than just a regular company*, even though it resorts

to a neutral *regular company* status when confronted on its role in pharmaceutical marketing.

On one level, IMS Health establishes itself as a company that is beyond typical profiteering, arguably altruistic in its alignment with the goals of the health care community. Although the company describes itself as “the leading provider of business intelligence and strategic consulting services for the pharmaceutical and healthcare industries”,⁵³ its website outlines a commitment to corporate responsibility in the advancement of “global health”, “ethical business conduct” and on-going involvement with communities. Not only does the company express a concern with privacy issues, as stated in its “worldwide commitment to information stewardship”,⁵⁴ but it expresses a “public good” duty as well. Under its *Company Background* description, IMS Health Canada claims to support “the public interest by providing information to health researchers and patient groups at no charge.”⁵⁵ It therefore enjoys a connectedness with several groups of health stakeholders and university-led research programs, to whom it provides information products.

On another level, the statements give no preference to any specific clientèle group. They maintain a neutrality towards all potential clients across public and private spheres of health care provision. By focusing primarily on the quality of its information products, the object of its business, IMS’ statements are non-committal. The oscillation between these themes of public concern and neutrality pervades the discourse patterns explored below, many of which focus on similar dimensions of the conflict as discussed in physician discourse.

1. IMPROVING THE SCIENCE OF MEDICINE

Where physician statements distinguish between “real science” and “commercialized science” in medicine, industry statements propose a different perspective: pharmaceutical intelligence will improve medical knowledge and increase the health care system’s overall efficiency. Data-mining, for example, can lead to drug marketing that is less wasteful, more profitable and “less annoying to doctors” (AFX International Focus, 2007, “States Cracking Down on Drug Marketing”). As a matter of principle, any business that knows its customers well can contribute to “the delivery of less expensive and more useful products and services” (Tindall, 2003: 185).

IMS’ statements also showcase the company’s whistle-blowing activity on issues such as the over-prescription for certain drugs, as well as its provision of prescription profiles to physicians free of charge as an auto-evaluative measure. Data-mining and all that accompanies it in terms of marketing, is not the problem in health care, *it is the solution*. As Tindall (2003) explains, “[c]onsumers are, therefore, largely trading privacy for a more efficient marketplace” (p. 185). Through a redefined concept of privacy, as expendable for the benefits derived from data-mining, industry expresses its understanding of a “good” health care system.

In the *Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology* (1999), Dr. Roger Korman, then President of IMS Health Canada, criticized Bill C-6 (which later became PIPEDA) because it would prevent the gathering of complete and uncorrupted physician prescription information towards “good health research”. This research would verify, for example, whether company-recommended dosages are being adhered to by doctors and patients (see Kermode-Scott, 2003b). The

improvement of medicine through transparency, for Dr. Korman, outweighs privacy needs: “[i]t is unhelpful to argue whether a system of health information that benefits society as a whole is more important than a person’s right to privacy or vice versa.” The industry justifies its right to physician data through utilitarian language and allusions to the greater “public good”. Dr. Korman added that such research is vital to the system because “patient compliance can be increased to the betterment of everyone.” Yet the neutrality, the reversion back to its pure business persona, appears later in the proceedings when Dr. Korman clarifies the *raison d’être* of IMS Health Canada:

We see our role in society of being able to describe authoritatively what is happening so that others can make policy to advance this nation’s health. We get caught up in these conflicts, but we are not here to choose sides on what is good health or good medical practice. We are here to provide authoritative information.

Dr. Korman’s statements offer a de-politicizing discourse that downplays the privacy issue as defined by physicians. Data-mining does not cause the wrongful distortion of medicine as a true science, rather, it enables sound health care policy-making.

2. “LET’S PUT THINGS INTO PERSPECTIVE”

Where doctors express outrage and deceit, statements by industry representatives defuse these reactions in various ways. Some statements clarify the extent to which physicians are vulnerable to exposure. The message is “we don’t have *that* much information on you”, or that the information is not as identifiable as doctors claim. An IMS spokesperson quoted in Sibbald (2003a), for example, maintains that the data-mining system is “not as precise as people might think” in that it “doesn’t say exactly what [doctors] prescribe” (p. 325). In most cases, the information merely indicates that a particular physician is grouped with others within a certain category of condition-specific prescribers (i.e. diabetes) (Milne, 2002b: 33).

The discourse challenges misconceptions about IMS by framing physician concerns as exaggerations of fact. Similar to how physician statements feature analogies to describe their personal experiences with privacy infringement, defensive statements feature analogies to frame the issue differently. An example is McMaster University professor Dr. Stuart MacLeod with the following statement:

It isn't fair to single out IMS because of the way its information gets used. It's like blaming GM when someone drives their car too fast [...] There are staunch critics of IMS but there is a danger of throwing the baby out with the bathwater (Milne, 2002b: 33).

In re-framing the issue, the discourse carries an altered doctor-patient power dynamic. Where physicians like Dr. Zoutman emphasize the protection of a skewed power dynamic in which the patient depends on the physician's expertise, the industry counters with the view that its information products can empower patients in this relationship. Not only do the products inform patients, they also serve as a check on physicians: knowing what (and how) they prescribe is a means of holding physicians accountable in their daily decision-making.

Industry seemingly has its own way of putting patients first. Following the Alberta Privacy Commissioner's ruling in 2003 that pharmacies are prohibited from selling prescription data to IMS Health given that the sale would violate the province's *Health Information Act*, the company disagreed on the grounds that "patient safety" and "patient health" would be at risk due to decreased information access (Kermode-Scott, 2003a). It also warned that the ruling could negatively impact the future of health partnership initiatives between IMS and the Alberta government (see also Whitney, 2006). Between physician and industry discourses, patients are caught in the middle within competing visions of health care. By stressing the harm that patients may be subject to as

a result of the Commissioner's ruling, the industry is letting us know that the system *needs* IMS. "Physician privacy" is conceptualized in a pathological manner and feeds into the public's declining confidence in medicine: to want privacy is to conceal what they do from public scrutiny – hence, the value of physician privacy is insufficient to warrant the desired protections, nor can it outweigh patient well-being as a policy goal.

Some industry statements diminish the significance of physician privacy, while others ironically emphasize the company's cooperativeness with concerned physicians. These statements, many of which are further explored in Chapter 3, demonstrate a willingness to negotiate data access compromises with medical associations. Clarke (2003) describes adaptive marketing approaches (i.e. research partnership programs) relative to resistant doctors⁵⁶ in an attempt to re-forge trust with medical associations and provincial governments. Sensing resistance, IMS has raised awareness of its activities and their benefits through mass correspondence to medical association members in Canada. It has also proposed an opt-out instrument for physicians in Alberta who do not want their prescription habits analyzed (Sibbald, 2003b).

From one public relations voice to another, the incongruities do not seem limited to the company's oscillation between its "public good" persona and "neutral market player" persona. Other incongruities lie in the ways that physicians are conceptualized. In industry discourse, what makes physicians gatekeepers of patient well-being – the boundaries of their therapeutic relationship – impedes patient self-empowerment. Physicians *get in the way* of the company's goals and hence their privacy ought to be diminished. Yet, undoubtedly the company still needs physicians to enable consumption. An aim of forced compromise is therefore conveyed in such discourse.

3. THE MEANING OF PRIVACY WITHIN THE INDUSTRY “HUDDLE”

The industry’s public relations voice is very different from its understanding of privacy when it talks exclusively to itself and its private sector *clientèle*. Internal statements are akin to shop-talk: more technical in describing the specifications of information products, as well as more concerned with the attractiveness of such products and less concerned with advancing health *per se*. An example is IMS Health Canada’s online description of its Electronic-Point-of-Sale systems, which clearly outlines its intention to provide “tracking data” to monitor the effectiveness of marketing campaigns and product launches.⁵⁷ The language is unapologetic and not at all self-conscious of the company’s surveillance capacities. Its focus on the technical renders the company indifferent to questions regarding the social underpinnings of physician privacy.

Industry discourse is driven by the need to know as much about doctors as possible, in terms of their prescription decision-making. When this is not expressed in the technical descriptions of their products, it is expressed in dollar figures. Some statements stress the importance of reinforcing the relationship between sales representatives and doctors given that one more prescription per week can mean additional tens of millions of dollars in annual profits. As Kallukaran and Kagan (1999) put it, “if you’re not targeting with the utmost precision, you could be throwing away a fortune” (p. 3).

The language is strategic in the manner it portrays physicians as subjects of marketing approaches. A good example is Blankenhorn *et al.* (2001), who summarize seven goals for successful pharmaceutical direct-to-consumer advertisement campaigns. One goal is to respect the doctor-patient relationship wherein “[t]he information provided must simultaneously improve the consumers’ ability to take control and manage their

own state of health while respecting and reinforcing the primacy of the physician role.”

These approaches take aim at physicians through patients as points of contact with industry. This is particularly noticeable in the article’s concluding finding:

When asked what it was about a particular ad that motivated respondents to discuss a medication with their doctor, one respondent in the IMS HEALTH survey answered, ‘hope’. For the empowered consumer, healing begins with hope borne of knowledge (Blakenhorn *et al.*, 2001).

Patients and doctors, here, are both subjects of a knowledge that is built around the ability to trigger consumption. The authors mention another approach which is to engage physicians directly by consulting with them on the design of an upcoming drug marketing campaign, so as to prepare physicians for the ensuing consumer (patient) interest. In contrast to the emphasis on the company’s collaborative nature, these internal discourses openly acknowledge and give priority to the direct persuasion of subjects.

Like physician discourse, some of the industry’s “internal” statements feature a militaristic tone. The most revealing *exposés* of the industry’s marketing strategies are awareness-raising, borderline sensationalistic, autobiographical works by former drug sales representatives. Focusing on the more unknown aspects of pressure sales, they reveal a process that connects the initial access of prescription data with their end products: physician profiling and persuasion. They reveal the machinery, or the consumption model, in which doctors are framed. In *Hard Sell*, former Pfizer salesman, Jamie Reidy, describes this model as conveyed in his sales training: “Frequently referencing Sun Tzu’s *The Art of War*, our instructors urged us to know our enemies better than we knew ourselves” (Reidy, 2005: 26). The training encourages an “us-versus-them” dynamic with both physicians and rival company sales representatives:

Doctors and competing reps alike routinely commented on a “Pfizer attitude,” a tangible vibe suggesting we were intrinsically better than any other salespeople.

Interestingly, army trainees emerge from boot camp with a similar sense of indestructibility, an unshakable belief that there could not be a more prepared soldier on earth (Reidy, 2005: 21).

Kathleen Slattery-Moshkau, who produced a film on pharmaceutical marketing entitled *Side Effects* (2005), also maintains that physician profiles “allow reps to enter doctors’ offices armed and dangerous” (Whitney, 2006). The discourse, as seen throughout the chapter, steers clear from philosophical discussions on the meaning of “privacy”. The statements do not offer clear definitions, although taken together they express the desire to thoroughly know doctors for the purposes of selling products, where the appropriateness of knowing doctors on such a level relates to questions of privacy and information access. This internal discourse thus acknowledges that the issue entails a confrontational relationship, in which information represents a means to a desired, profitable outcome.

CONCLUSION: THREE SHARED PATTERNS

There is nothing surprising about this internal discourse given that IMS is a private sector company. The oscillation among the different “voices” of industry, and the values and ideals that they emphasize, is not the most insightful pattern to emerge from the analysis. Physicians understandably oscillate in their discourse as well, strongly emphasizing patient well-being in some sources while justifying their expectations of privacy on purely professional grounds in others. Each camp has its own message about how privacy affects them, and it is broadcast across several channels with the expectation that these channels may interfere in certain ways.

In his response to the Paris Epistemology Circle in 1968, Foucault distinguishes the types of observations to be drawn from a discourse analysis. An analysis of thought

through discourse can ask itself: What, then, *was being said in what was said*? He stresses, however, that the question could be reformulated into: “What is this regular existence that comes to the fore in what is said – and nowhere else?”⁵⁸

There is no clear way of interpreting *what was being said in what was said*, in terms of determining whether physicians, for instance, were truly debating the greater “public good” of medical practice, or whether their discourse revealed a concerted effort to squeeze out – or better contain – commercial interests. Rather, the regular existence seen in the above statements, or the peculiarity that arises, is the parallel manifestations of three patterns found in both physician and industry discourses about privacy: (1) the concern with the maintenance (or development) of expertise, (2) the use of patient well-being as a mechanism to defend the maintenance (or development) of such expertise, and (3) the conceptualization of the counterpart as an enemy or an other.

In the first pattern, both diverge over the meaning of “good” or “real” medicine as a scientific discipline. Many doctors refer to a nostalgic, idealist and pure vision of medical expertise that defines the profession as it was prior to its complex entanglement with the pharmaceutical industry. The industry maintains a forward-looking vision of medical practice – pragmatically accepting of a public-private partnership in the development of medical expertise. The partnership, accordingly, is seen as a means of enhancing what doctors know.

In the second pattern, the parties diverge over the empowerment of the patient within the therapeutic relationship. Doctors seek to maintain the “classic” power dynamic in which they occupy a gatekeeper role in deciding what is best for their patients. Industry seeks to empower patients in rendering their awareness of pharmaceutical

products influential upon doctors' decisions regarding the proper treatment to pursue.

In the third shared pattern, as seen in the use of militaristic jargon, they conceptualize each other as mutual obstacles in the attainment of their respective visions of health care. They draw clear distinctions between themselves and the other, illustrated by the ways in which they antagonize the other – arguably in recognition of how the mastery of “privacy” could displace their counterpart’s socio-political sway.

As mentioned earlier, within both sites of discourse, these patterns emerge in a parallel manner. They develop independently of one another. One set of statements may take cues from what is said, or triggered by the practices of the other, as was seen in IMS’ downplaying of the alleged completeness and identifiability of the information gathered on doctors. Beyond this aspect of interaction, dialogue between doctors and industry is generally absent. They do not contest one another on their respective understandings of “privacy” – or the semantics of these understandings. In speaking about privacy, physicians and industry representatives say more about themselves than each other. In various ways that are explored in Chapter 3 using Foucault’s writings on the conceptual interplay between power and knowledge, they generate a perception of themselves within a network of power relations. The next chapter thus delves into the complexities of this dynamic in order to understand the types of mobilization initiated by doctors in regards to their privacy.

Chapter 3: Intricacies of power

The previous chapter found a lack of debate over the meaning of “privacy” in physician and industry discourses. The patterns in the concept’s usage, however, seem to focus on aspects of the physician-industry dynamic that may – or may not – warrant a notion of “physician privacy”. The patterns are indicators of a complex network of power relations through which allusions to this concept materialize.

This chapter shifts the approach from the *existence of what was being said* to the *triggers* of these discourses. Again, Foucault’s writings on power and knowledge can provide insights as to the nature of these triggers. In his interview with Gérard Raulet in 1983 entitled *Structuralism and Post-Structuralism*,⁵⁹ he clarifies the aim of his writings: “I am not developing a theory of power. I am working on the history, at a given moment, of the way reflexivity of self upon self is established, and the discourse of truth linked to it” (p. 96). Foucault’s understanding of power, as a capacity to influence the behaviour of another, is central to the depiction of this process:

I mean that in human relationships, whether they involve verbal communication such as we are engaged in at this moment, or amorous, institutional, or economic relationships, power is always present: I mean a relationship in which one person tries to control the conduct of the other. So I am speaking of relations that exist at different levels, in different forms; these power relations are mobile, they can be modified, they are not fixed once and for all.⁶⁰

Rather than monitoring shifts in political power, Foucault stresses the importance of studying everyday manifestations of influence. The approach accounts for the subject’s enjoyment of a certain level of freedom as a necessary condition for a power relation to exist, to the extent that “some men can more or less entirely determine other men’s conduct – but never exhaustively or coercively.”⁶¹ Power, in other words, depends on the potential for resistance and reversal against attempts to determine conduct. There is such

potential in the dynamic between physicians and the pharmaceutical market surveillance industry, particularly in cases where physicians confront surveillance practices – which fit within Foucault’s conception of discipline. In describing the layers of this discipline, the manners in which this discipline is fundamentally concerned with expertise, as well as the multiple points of interaction it shares with physicians, I depict an elaborate network in which power relations “intersect, interrelate, converge, or, on the contrary, oppose one another or tend to cancel each other out.”⁶² The privacy issue as presented in Chapter 2 gains another dimension in this chapter, that is, the degree of entanglement and mutuality between both camps – as well as the subtleties that define their opposition.

DEMAND FOR KNOWLEDGE, DEMAND FOR DISCIPLINE

Similarly to the ways in which delinquency, deviancy or madness “progressively took [their] place in the positivity of known things” (Foucault, 2006: 443), prescription decision-making has become an area of empirical study due to the consumption enabled by physician activity. Physicians, like their patients or any other surveilled population, become objects of knowledge through discipline – where discipline theoretically encompasses “a whole set of instruments, techniques, procedures, levels of application, targets” (Foucault, 1977: 215). The notion of discipline does not entail a system that is necessarily authored by one particular institution or entity, rather, the impact has numerous forms and means so as to acquire thorough knowledge about an individual’s conscience and the ability to direct it.

There is evidence of discipline in the effects of power observed in recent studies on prescribing practices. An example is Zoutman *et al.* (2008) which explores factors that impact physicians’ prescription of antibiotics for upper respiratory tract infections. The

potential limitation of their study, the authors note, was its reliance on self-reported prescribing data and may be skewed by the tendency to report habits in a favourable light. Despite the limitation, the study found patterns suggesting that the industry influences physicians' decision-making. An earlier study that was published in the *European Journal of Clinical Pharmacology* in 2000 explored the causality between drug representative-physician interactions and an increased likelihood that physicians will not prescribe in their patients' "best interests" (Whitney, 2006). A more comprehensive study developed by a collaboration of Canadian, Australian and Malaysian researchers was recently published in *PLoS Medicine* which statistically examined the "relationship between exposure to information from pharmaceutical companies and the quality, quantity, and cost of physicians' prescribing" (Spurling *et al.*, 2010: 1). From its findings that prescribing-curbing is made possible through exposure, the study recommended that physicians exercise precaution and avoid exposure to information provided by pharmaceutical companies (p. 22).

Another effect of power is the displacement of medical expertise. Former drug salesman Jamie Reidy (2005) describes how his profession, enabled by specialized knowledge about physicians and their prescribing habits, lead him to occupy certain functions of the medical profession:

Pretty soon, I began handing out [drug] samples to friends and family members who coughed in a way I didn't like. Without the aid of throat cultures or even a stethoscope, I became a *de facto* doctor, replacing expertise in medicine with access to medicine (p. 63).

The displacement phenomenon is also manifested through the creation of medical liaisons or officers. These individuals can be PhD graduates, physicians or even nurses who have "extensive knowledge of the pharmaceutical industry and the health-care field"

and “act as professional intermediaries between physicians and pharmaceutical companies” (Clarke, 2003). Medical expertise, in terms of what it consists in and who commands it, is shifting towards an expertise about products stemming from the industry itself. Today’s physician, in other words, is not the only “expert” in medicine. Studies such as those carried out by Spurling *et al.* (2010) scratch the surface of questions regarding the degree to which actors like sales representatives and liaison officers partake in the development of medical expertise, and whether they are guiding or leading this development process.

Foucault’s notion of discipline therefore illustrates that data-mining is only one component of the ability to influence physicians. Although it is the initial point of access into the physician’s conscience, discipline encompasses a multitude of other mechanisms that reach, surround and involve the physician’s decision regarding drug treatments. Confronted with these mechanisms, physicians become subjects of a normalizing power that seeks an understanding of their conscience, and seeks to maintain its subjection.

A body of knowledge continuously grows for the life of the subject. As explained by David Blumenthal (2004), interactions between physicians and industry “begin in medical school, continue during residency training, and persist throughout physicians’ careers” (p. 1885). The relationships change as physicians mature, yet there is an overarching aim of achieving perfect knowledge about them. To do so, market surveillance companies combine data from various sources. Adriane Fugh-Berman and Shahram Ahari (2007) describe how one company, Medical Marketing Service, supplements the data contained in the American Medical Association Masterfile (which identifies all doctors in the U.S.) with demographic data, patient longitudinal data as well

as behavioural and psychographic data to improve targeting. What these approaches seek is a dynamic snapshot of “physicians’ behaviour relative to switching, titration, new therapy starts, new patient starts, and concomitant therapies as well as more traditional research, such as physician prescribing and overall promotional data” (Brand and Kumar, 2003: 2). As the authors explain, the goal is “a robust understanding of physicians as human beings, with distinct sets of attitudes and values” to enable companies in their assessment of medical needs. The overall aim is to grasp the physician’s complexity as a whole, so as to render him or her predictable and malleable as a subject.

In IMS’ privacy discourse, the aim of perfect knowledge is emphasized in the company’s insistence on having *all* doctors included in their databases for the purpose of maintaining purity and consistency throughout the collected data (Kermode-Scott, 2003b). The value of its databases is depleted if physicians resist or opt-out of the surveillance system. Without a complete ensemble of data items, one cannot accurately gauge a physician’s responding behaviour relative to marketing campaigns.

Apart from the drives of this normalizing power, Foucault’s discussion on “the art of punishment” describes the modes through which this power is operationalized:

[I]t refers individual actions to a whole that is at once a field of comparison, a space of differentiation and the principle of a rule to be followed. It differentiates individuals from one another, in terms of the following overall rule: that the rule be made to function as a minimal threshold, as an average to be respected or as an optimum towards which one must move. It measures in quantitative terms and hierarchizes in terms of value, the abilities, the level, the ‘nature’ of individuals. It introduces, through this ‘value-giving’ measure, the constraint of a conformity that must be achieved. Lastly, it traces the limit that will define difference in relation to all other differences, the external frontier of the abnormal (the ‘shameful’ class of the *École Militaire*) (Foucault, 1977: 182-183).

In the physician-industry dynamic, a similar series of mechanisms structure the surveillance of physicians. In 1997, IMS Health Canada and IMS International were

selected to be the site of a \$40 million data-warehousing project in Quebec. The company's director of information systems at the time, Alvaro Mestre, describes the project's goals of transitioning from a traditional to a dimensional database design wherein "[t]he data is packaged into groups and subdatabases that support a family of business questions, so if you're trying to look at correlations between prescriptions and therapy you would create a database for that" (Sibley, 1997). This new database design is one example of how a mechanism has shifted towards a more comprehensive means of "giving value" to physicians according to their decision-making habits.

"MECHANICAL" DISCIPLINE: THE PANOPTIC SORT

Moving away from Foucault expressly, Oscar Gandy Jr.'s notion of the *panoptic sort* can also expand on the mechanisms that structure market conceptions of physicians. The notion refers to the free market's gaze which "operates to increase the precision with which individuals are classified according to their perceived value in the marketplace and their susceptibility to particular appeals" (Gandy, 1993: 2). The sort is a process through which market surveillance companies gather "electronic fingerprints" about individuals as consumers (King, 2001: 40). With these fingerprints the panoptic sort identifies, classifies and assesses individuals. Identification entails the tagging of an individual, wherein a personalized name and identity is attached to the body of information on him or her. Classification then controls for the diversity of possible consumer behaviours by grouping individuals into "workable categories" based on shared characteristics (Arvidsson, 2004: 459-460). Consumers are consequently assessed by being placed into circuits of inclusion and exclusion (Gandy, 1996).

The inclusion-exclusion aspect is illustrated in the analysis by Richard Ericson,

Dean Barry and Aaron Doyle (2000) of the insurance industry's surveillance system.

Applying Gandy's notion, they observe the classification of individuals "into pools of standard, sub-standard, and uninsurable risks" where such systems "magnify differences among individuals in order to achieve greater precision in the commodification of insurance products and exclusion of those who do not fit" (p. 534). Through the processes of identifying, classifying and assessing, a power asymmetry is manifested between the *surveilled* and the *surveillor*. Physicians face these processes in a similar manner: they are identifiable through their market-oriented individualities, which are comprised of estimations relative to prescribing ideal-types. These scales of measurement stabilize an understanding of prescribing activity across short and long periods of time. Every market surveillance company and drug manufacturing firm has its own set of scales. Fred Marshall, president of Quantum Learning, offers one typology of physicians:

One type might be called 'the spreader' who uses a little bit of everybody's product. The second type might be a 'loyalist', who's very loyal to one particular product and uses it for most patient types. Another physician might be a 'niche' physician, who reserves our product only for a very narrowly defined patient type (Fugh-Berman and Ahari, 2007: 624).

There is even a "hidden gem" category of physicians who are deemed low prescribers yet susceptible to change with the right marketing approach. Some typologies delve into finer, more granular, personality traits. The study by Ahari and Fugh-Berman outlined a set of physician personality types ranging from "friendly" to "aloof" – each corresponding to marketing strategies used by drug sales representatives to impact their prescribing habits (see Appendix D).

The panoptic sort has a divide-and-conquer effect, in which physicians are identified, classified and processed according to their market value. Circuits of exclusion and inclusion emerge, to the extent that physicians receive varying levels of market

attention based on their respective constituted individualities. An example is the development of prioritized “Heavy Hitter” lists by drug sales teams, which rank targeted doctors according to their susceptibility to influence. The hierarchy embedded in such lists results from profiling that determines which doctors are *worthy* of the perks (i.e. free dinners, tickets to sporting events) offered by sales representatives during their detailing visits (Whitney, 2006). Accordingly, an apparatus emerges where subjects are framed by a system of values regarding prescribing activity. Subjects are born from evaluation scales that measure such activity and in turn, the measurements base the development of protocols that are designed to impact subjects. If a physician, for example, is deemed an “early adopter” (or more affectionately, a “cowboy”) because he tends to prescribe new drugs shortly after market release, the protocol is to visit him or her pre-emptively in order to maximize its consumption upon the drug’s release.

The panoptic sort illustrates the machine-like character of the gaze, however, it is not an automatic, purely mechanical or algorithmical entity. The system’s effectiveness in curbing prescribing habits lies in human interaction as well. The subtlety of the discipline is due to interpersonal relations, through the sales representative’s use of knowledge about the physician’s “conscience”.

“HUMAN” DISCIPLINE: THE DRUG SALES REP

For Gandy, all information about an individual is potentially useful in determining his or her commercial value (King, 2001: 45). Within this perspective, the sales representative embodies the system’s ability to gather the information that cannot be drawn from prescriptions. The human element, the salesperson, is an instrument through which

marketing tactics are improvised to learn about physicians, and to steer their decision-making.

According to Reidy (2005), a sales representative's job is to "[p]rovide health-care professionals with product information, answer their questions on the use of products, and deliver product samples" – the more accurate description of the job, he later adds, is to "[c]hange the prescribing habits of physicians" (p. 65). Former drug representative Shahram Ahari similarly recalls that his job consisted in determining "a physician's price" (Mick, 2007). To achieve this aim, the scope of information to be gathered about a physician extends into everyday life – whether inside or outside the clinic, hospital or office. The sales representative uses strategies such as scanning offices for "novels, sports equipment and even religious symbols" to establish a personal connection with the physician (Mick, 2007). A family photo on a desk, for example, is an opportunity to ask about his or her children or spouse, their birthdays as well as schooling and leisure interests. Whatever information a physician offers in response to these questions can be recorded into a database after the visit (Fugh-Berman and Ahari, 2007: 621). The cumulative knowledge derived from these interactions can subsequently be used to secure the physician's loyalty to the marketed drug over its competing brand (Mullin, 2007). This function of knowledge, to convince and secure, is illustrated in what is known in the sales industry as "the closer". According to Reidy (2005), a closer is "a guy who asks for the business, a guy who breaks docs down and gains a commitment to use our product" (p. 9). The underlying presumption of the surveillance system is that the doctor is to be "broken down" – and that influence is enabled by this process as a result.

LAYERS OF DISCIPLINE: THE “DISCIPLINED” SALES STAFF

While Gandy’s notion of panoptic sort is useful for exploring the machinery of the system, Foucault’s writings on panopticism illustrate the process through which subjects are “broken down”. Panopticism is a mechanism of power that is associated with the institutional design of Jeremy Bentham’s panopticon prison. This structure consists in a circular building with several stories of separate cells with an open face oriented towards a central all-seeing tower (Foucault, 1979: 173; Haggerty and Ericson, 2000: 607).

Inmates cannot see into the central tower to determine whether they are being surveilled, yet aware that the warden inside the tower can hypothetically monitor any cell at any given time. For Foucault, panopticism acts on the mind, and exerts control through an ability to “penetrate into man’s behaviour” (King: 42-43). It is a mechanism of power given that subjects tend to engage in behavioural self-modification in response to the uncertainty of being scrutinized.

It is possible that panopticism is a mechanism of power that characterizes physician-industry relations. Physicians may be subject to a gaze where their conduct is scrutinized, with an element of uncertainty, towards an end of behavioural self-adjustment. To react by self-adjustment, however, doctors would have to be aware of the ramifications of being “seen” by the industry. Physicians would need to be sufficiently aware to feel a sense of uncertainty about being watched. In reality, despite the growing body of evidence that doctors are subject to influence, they generally remain unaware of the ways in which they are being watched. “I never thought about what happened to a prescription I wrote after I wrote it”, explained Nevada state senator (and physician) Joseph Heck in an interview regarding data-mining practices (Mullin, 2007). The

pervasiveness of the surveillance system lies in its ability to function without its effects being noticed by subjects. It is so diffuse and subtle in its operation that physicians are not entirely aware of the scrutiny they face on a regular basis.

In this particular case, panopticism does not tell us much about how doctors are “broken down”. Ironically, there is a greater evidence in Jamie Reidy’s account of his drug detailing career to suggest that sales personnel are more reflective of a panoptic surveillance system. They are mechanisms through which power relations take shape: to carry out their functions, sales representatives not only have to *see* their subjects – as the eyes of the apparatus – they are subjects themselves who are *seen* by a different wing of the apparatus.

The productive aspect of panopticism, according to Foucault, is that individuals constitute themselves as “useful subjects, men and women who conform to a standard, who are certifiably sane or healthy or docile or competent, not free agents who invent their own standards, who, in the language of rights, ‘give the law to themselves’” (Hoy, 1986: 59; see also Foucault, 1979: 170). As indicated throughout Reidy’s account, the sales representative embodies this constitution of a “useful subject”. He is a product of marketing knowledge who is trained to govern himself through a system of quotas associated with “good” salesmanship. Brownlee and Lenzer (2005) illustrate the type of training program that representatives undergo once they are recruited:

The reps are schooled for weeks in a variety of sales techniques. They memorize tightly crafted speeches and volumes of data on their products, and some are even trained in personality profiling, to help them guess whether a physician is more likely to respond to reams of scientific research or to schmoozing. Prescriber reports play a key role in helping reps boost sales – they’re like weekly focus groups that help reps shape their pitches to individual doctors. If Doctor A increased her prescriptions after being treated to a facial and full-body massage, more expense-paid spa excursions are in order for her. If Doctor B didn’t respond

to a courtesy five-course meal, then maybe it's time to try football tickets, or up the free drug samples, or plug clinical research that touts the proffered drug's benefits.

A commercial value system is taught to the trainee. When applying what he learned to doctors, Reidy viewed his job as though it were a professional sport. His accounts of day-to-day experiences resemble a baseball player's autobiography, complete with performance statistics throughout the highs and lows of his career. An example is his attempts at improving his sales of the antibiotic Trovan (Zithromax):

By the end of May [1999], I ranked seventh in the nation at 160 percent, but this number belied my actual position since my weekly sales were still trending upward while those of the six reps ahead of me were falling, due in large part to competitor's spreading news of Trovan-related liver failures in the first half of that year. Fortunately, no patients in my territory had experienced this tragic event, and my doctors continued prescribing it. I was finally kicking ass! Until June, that is (p. 198).

At several points, Reidy reflects on his career as an experience akin to being brainwashed or indoctrinated through an obsession with the value system and the defining career numbers inherent to his salesman individuality.⁶³

On a more symbolic level, panopticism is illustrated in Reidy's account of a training component where trainees are videotaped as they perform a drug detailing pitch to a hypothetical doctor: "It was truly amazing to watch what happened to people after that red light flicked on, myself included. Former fighter pilots froze, veteran sales guys stammered and stuttered. Seemingly superconfident people collapsed in front of the camera" (p. 35). We see the breakdown of behaviours in trainees as the camera records their every act. The training is intensive, there are continuous evaluative follow-ups and towards the end of the program, Reidy admits, he began to dream about product-vending.

Panopticism exists in other monitoring techniques that parallel Foucault's discussion in *Discipline and Punish* (1977) regarding the Panopticon's ability to

scrutinize its own mechanisms. From the central tower “the director may spy on all the employees that he has under his orders: nurses, doctors, foremen, teachers, warders; he will be able to judge them continuously, alter their behaviour, impose upon them the methods he thinks best; and it will even be possible to observe the director himself” (p. 204). The purposes are to record attendance, to determine the location of subjects so as to intercept them or to simply evaluate their conduct according to desired outcomes. These aspects are similarly present in the pharmaceutical surveillance apparatus. Central to the techniques used to monitor sales representatives, according to Reidy, is the role of the sales district manager:

A district manager’s main job was to monitor and modify behaviours. For a person managing new reps, however, his most important task was to *create* those behaviours, to instil in his people the need to make ten sales calls every day, during which they would detail at least two products and close the physician for a specific number of future patients. Having created such a behaviour pattern over the course of several months, the DM could then encourage certain habits, tweak others, and overhaul the remainder (Reidy, 2005: 47).

Other tactics to keep sales staff “in line” include the monitoring of daily expenses.⁶⁴

Representatives typically receive an American Express card for visit expenses (i.e. lunches, dinners), in turn, AmEx provides the company with statements of the representative’s transactions, to prevent frivolous personal expenses beyond the usual marketing perks offered to physicians (Reidy, 2005: 101).

In briefly examining the microcosm of drug salesmanship, the whole of the surveillant apparatus is now characterized by various levels of complexity beyond the immediate power relations that exist between physicians and industry. The sales representative alone, as an important cog in the proverbial marketing wheel, is surrounded by a field of power through which he or she is constituted as a subject. In his book, Jamie Reidy essentially describes himself as the product of a discipline which was

deployed as a mechanism of power, as someone who was not “complete” or truly himself, but rather constituted within a more limited (yet domineering) salesman individuality.

Both doctors and sales representatives are arguably products of different disciplines, yet also find themselves in a situation of mutual subjectification. Foucault’s conceptualization of power as capillary provides these various dimensions through which the surveillance apparatus reaches and encircles physicians. Power has no centre yet “it reaches everywhere”; it is dispersed and its forms are heterogeneous, in the sense that they may not always be exercised upon the individual in a direct manner.⁶⁵ In a similar manner, sales representatives do not focus all their marketing efforts on physicians only. Certain tactics take aim at their surrounding staff. Jamie Reidy, for example, would invite nurses to happy hour events to “thank them for their help in encouraging Dr. X to prescribe Zithromax” (Whitney, 2006). The tactics encircle the physician, or in Foucault’s terms, they can shape “the field of other possible actions” that surround the subject (Rabinow and Rose, 1994: 140). It is within this conceptualization of power as capillary that mechanisms of influence can be examined more closely, in terms of how they are applied in everyday one-on-one interactions between doctors and sales representatives.

BREAKING DOWN DOCTORS

The sales representative-doctor dynamic is characterized by use of subtle (and not so subtle) modes of interaction to influence physicians. An inherent instability in this particular dynamic can be observed – given the documented flare-ups of resistance where physicians *bite back* with affirmations of their authority. At the same time, these

manifestations occur within the relatively stable rapport between the parties, in which cooperation and mutual support can also be observed.

Kate Rawson (2007) recounts one incident that led to the California Medical Association's campaign against prescription data-mining. The irritant was a conversation at a cocktail party, in which a drug representative described in "excruciating detail" the prescribing habits of the obstetrician he was speaking with. The obstetrician in question eventually authored a resolution that passed in the Association's House of Delegates in 1999, which stated that prescribing information "should not be used for marketing purposes." Later in 2003, another resolution was passed to establish the Association's support of an anti-prescribing data bill that nearly passed in the California state legislature.

The irritant underlying a similar resolution drafted by the American College of Physicians was a conversation that took place at a children's soccer game among parents, one of which was a drug representative and the other being a primary care physician. In another incident, an ophthalmologist in Nebraska grew annoyed with a drug salesman and afterwards, spoke about his encounter with his neighbour who happened to be state senator Kermit A. Brashear. Following the incident, Senator Brashear has regularly attempted to pass legislation that bans the collection of prescription data (Rawson, 2007: 13).

What makes these interactions irritants, and sources of organized resistance, ranges from *knowing too much* to being offensive with the use of bold and unusual selling tactics. Jamie Reidy (2005) recounts one incident whereby a Biaxin salesman had thrown a Kermit the Frog puppet onto an internist's desk as a means of informing him

that Jim Henson was taking a competing antibiotic for pneumonia when he died. When told to “be sure to use Biaxin first line” to prevent a similar fate for his patients, the internist took offense and threw him out – barring the representative from returning to the office (pp. 165-166). These catalysers illustrate a sensitivity, or a fine professional boundary between stable rapport and disrespect. That boundary, in turn, is a subjective construct. Not all doctors would be offended by the “Kermit the Frog” antic, nor would all doctors be suspicious of receiving free drug samples, nor feel awkward about offering their verbal commitment to a sales person to ensure that such samples are continuously provided. According to Blumenthal (2004), the overall tone of sales representative-physician interactions is accommodating:

Most physicians are quite tolerant of, and even have a positive attitude toward, their interactions with drug companies. Many physicians believe that their interactions with drug companies have educational value for themselves and also provide benefits for patients, both because physicians are kept informed about available therapeutic agents and because the free samples they are given can be distributed to patients (p. 1887).

In the introduction to *The Essential Foucault*, Rabinow and Rose (1994) note that Foucault’s analyses of “emergent areas of governance” highlight a key point that “no simple lines could be drawn between reformers and reactionaries, between those ‘on the side of power’ and those ‘on the side of resistance’” (p. ix). This lack of a clear dividing line is also present in the context of the physician privacy issue. The offended obstetricians, internists or ophthalmologists may be “on the side of resistance”, yet these individuals are ultimately part of a group of specialized professionals that is internally divided by its members’ perceptions of the pharmaceutical industry.

The inner cohesiveness of the industry is just as fragmented and blurred, as seen with individuals like Jamie Reidy who depart from their marketing careers to

communicate lesser known dimensions of the industry. Not all sales representatives conceive the physician as an “other” to be thoroughly known. Some may not consider their role as narrowly concerned with doctor-swaying and see themselves as a genuine assistance to doctors in their daily decision-making.

The discourse analysis in Chapter 2 illustrates the blurry distinction between “those on the side of power” and “those on the side of resistance”. Although the chapter explored patterns within a divided analysis of physician discourses and industry discourses, thus presuming a physician-industry dichotomy, what emerged from the analysis was a fragmented body of understanding about privacy based on differing experiences and ideals about health care provision. Industry representatives and doctors are not exclusively divided into homogeneous camps of resisters and offenders. As explained by Paul McNeill, a bioethicist at the University of New South Wales, “[d]octors are sometimes seen as the innocent victims, and the villains in the piece are the pharmaceutical industry” (Fyfe, 2006). The reality is more complicated: a free lunch is not only a mechanism to pressure a physician, it is also an opportunity for the physician in need of research funding from the drug firm in question (Moynihan, 2003: 1191).

Whether there is resistance to (or compliance with) marketing pressure depends on physician subjectivity with regards to their perception of the industry. The significance of perception is illustrated in the types of responses physicians have to different mechanisms of influence. Apart from being generally cooperative and even dependent upon sales staff, in many cases, physicians are not fully aware of the extent to which they are influenced – while others are in denial of their vulnerability.

For instance, some physicians do not recognize that their interactions entail bartering with sales representatives so as to benefit their medical practice (i.e. securing supplies of free drug samples). Former representative Shahram Ahari remarked that “[d]octors are neither trained nor paid to negotiate” and may not realize that their interactions are acts of negotiation (Fugh-Berman and Ahari, 2007: 624). Other physicians may be aware although not cognizant of the fact that they are being swayed by the bartering itself. One sales technique in which the awareness of negotiation can be circumvented is the representative’s emphasis on a drug’s “feature to benefits”. These are positive impacts of the drug’s usage on the everyday lives of patients and doctors. The negotiation’s success hinges on the representative’s ability to encourage the physician to evaluate the drug’s impacts, not in terms of the material perks he or she would receive, but in terms of how its prescription may render their lives more convenient (i.e. shorter dosage period).

Gift-giving is another sales technique that employs a different mechanism of influence. An analysis by Katz *et al.* (2003) found that offerings of food, flattery and friendship were powerful tools of persuasion in encouraging physicians to comply with market campaigns. The obligation to comply lies in the asymmetry that arises from one party offering a gift to the other. For former representative Shahram Ahari, this asymmetry is manifested in situations such as free dinners, where the physician may be “eating with a friend” yet the representative – from his or her perspective – is assuredly “eating with a client” (Fugh-Berman and Ahari, 2007: 621). The way in which representatives conceptualize their counterparts creates an indebtedness that is repaid through the physician’s support for the marketed drug (Moynihan, 2003: 1192).

Gift-giving does not guarantee compliance, nor does the sales staff have “punitive power” *per se* over physicians with such tactics.⁶⁶ It remains however that these tactics exist within a marketing lore that is taught to trainees and regularly applied on doctors – and proven to be effective through the collection of prescribing information.

Beyond varying degrees of awareness of the fact that they are subject to mechanisms of influence, physicians also respond through forms of denial. Some physicians express an awareness of pharmaceutical marketing techniques and their purposes, yet they maintain a conviction of their immunity to their effects. They may strongly deny, for instance, that they can be influenced by low-order tactics:

What’s harder to understand is doctors’ insistence that they’re unmoved by the approximately \$15 billion that drug companies spend annually on marketing (compared with \$33 billion a year on research and development). Plenty of evidence shows that they’re easy marks. Several published studies have found that doctors who rely on reps for their information have more expensive prescribing habits than those who stick to the medical journals (Brownless and Lenzer, 2005).

According to Adriane Fugh-Berman, an associate professor at the Georgetown University’s School of Medicine, even medical students refuse to accept the insinuation that doctors can be influenced by the industry. “Physicians do not believe that they are affected by pharma,” she explains, “They all say the same thing: ‘We are too smart to be bought by a slice of pizza’”.⁶⁷ Other physicians believe that they are themselves immune against the tactics but that other doctors, their peers, are more vulnerable:

In one survey, 61 percent of the residents at the University of California, San Francisco Medical Center reported that they themselves are unmoved by drug company gifts. But when asked if they thought their colleagues were swayed, 84 percent said yes (Brownlee and Lenzer, 2005).

How physicians deny their vulnerability indicates the degree to which the profession cohesively asserts its own autonomy, and the extent to which individuals assert their own autonomy within the climate of the profession itself. These manifestations of denial and

awareness therefore contribute to an overall understanding of the power dynamic between the profession and the industry. Individual perceptions of the industry, combined with perceptions of the profession's status in health care – relative to the industry, relative to the public – shape physicians' responses and the types of organized resistance or acts of compliance that may result. The nature of power not only reveals itself through the mechanisms of influence that comprise a surveillant apparatus. One can gauge the dynamic based on the subject's responses to such mechanisms as well and the factors that may shape these responses. In this particular case, the apparatus blends into the everyday experiences of doctors⁶⁸ – to the extent that the outcomes of the apparatus (modified prescription habits) are often met with surprise or disbelief due to a general lack of awareness about the ways in which they are objectified. Alternatively, as seen in the “we can't be bought by a slice of pizza” mentality, this disbelief is rooted in the profession's view of itself.

CONCLUSION

As mentioned earlier, Foucault's writings do not propose an actual theory of power. His approach lies in the consideration of power and knowledge as an analytical grid.⁶⁹ The grid enables an exploration beyond *what is being said* to the types of relations that shape these debates about physician privacy. This conceptualization – founded on the ability to influence another, capillary and two-way in nature, an on-going process within a multifaceted series of mechanisms, while productive in its constitution of subjects – provides the analytical granularity needed to understand how these debates relate to power.

Oscar Gandy Jr.'s writings on the panoptic sort and Foucault's discussions on discipline, to this end, open up an understanding of the surveillant apparatus that is both an actuarial machine-like body, and an organic self-modifying structure. Discipline and panopticism also shed light on a sub-area of power relations that exists separately from the subjectification of doctors: the subjectification of sales representatives to ensure the effectiveness of the apparatus itself. A focus on the dynamic between the representative and the physician illustrates how discipline encompasses the "human" aspect of surveillance, wherein interpersonal contact is used to complete the body of knowledge. These interactions are characterized by attempts to influence physicians in everyday circumstances, using everyday conversational means, which can lead to varying degrees of organized resistance or compliance. These levels of cooperation reveal the flip-side of power in which doctors and industry mutually benefit from each other's presence in health care provision. Amidst this array of possible responses, the sales representative stands as a central figure in shaping physicians' perceptions of themselves relative to the industry's presence in health care.

What emerges from the power-knowledge grid is the further deepening of the context associated with privacy discourses, which now features a complex assemblage of surveillant components that physicians regularly encounter throughout their careers. By looking at these components individually, and the types of responses that physicians have towards them, one finds that the effectiveness of this assemblage depends on subjective physician perceptions. Perceptions (de)activate power: a physician's awareness and sensitivity to one's professional being, in interaction with the industry, shape the discourse and its subsequent translation into concrete action against the pharmaceutical

industry. The following chapter explores how mobilized action has emerged from this depicted network of intersecting, converging and opposing power relations. Power as manifested within its different modalities in law and policy is the focus of Chapter 4.

Chapter 4: Modalities of resistance

In Chapter 1, a social landscape was depicted in which doctors face heightened public scepticism regarding *what they know* as a result of the democratization of their knowledge and the proliferation of related specializations.⁷⁰ Exclusive command over medical expertise, and the privilege it enables, has arguably lessened as a result – to which an assertion of “privacy” can (in theory) become a means of gaining control and countering the effects of this socio-political decline.

The first chapter also depicted the reality that such attempts encounter obstacles commonly confronted by theorists, legislators and judges – notably the inherent conceptual awkwardness of “privacy”. Not only does the concept vary according to context and subjective experience, but it is constantly weighed against the potential benefits of its infringement. On a broader level, according to some authors, the concept is simply losing its importance over time. This is particularly noticeable given society’s growing tolerance towards a “new openness” in which individuals share – with greater ease and willingness – aspects of their personal lives through social networking sites like Facebook (Rennie, 2008: 8).

A “new openness” similarly pervades the health care sector as it considers new methods of streamlining service provision by foregoing patient privacy. Medicine, for instance, enthusiastically points to a pending era of personalized medicine that enhances “the general social welfare” by privileging open access to “[d]etailed and accurate health and genetic information from private medical histories” (Dyson, 2008: 50). Privacy is becoming an increasingly significant theme in these particular contexts, though the emerging view is that privacy protections ought to be compromised to enable the benefits

of information-sharing and openness. This trend exists within general social contexts as well as the specialized sphere of medicine, thus making the task of concretizing a viable right to privacy a difficult one for physicians. Chapter 1 therefore sets a level of difficulty that contextualizes an exploration of the modalities through which a meaningful notion of “physician privacy” can be realized. To an extent, chapters 2 and 3 addressed aspects of this exploration by focusing on discourse (as a modality rooted in expression) and day-to-day types of interaction between doctors and drug sales representatives (as modalities rooted in action).

In Chapter 2, I demonstrated how discourse patterns provide different ways of framing the objectionable nature of prescription data-mining. In explaining the reasons why privacy is meaningful to doctors, or why information access is a justifiable activity for data-mining companies, discourse offers pieces of a desired reality, or a loosely envisioned “law” regarding this reality. For physicians, it is a law describing what it is about the perceived infringement that is offensive and points to remedies the State may pursue to intervene favourably. Comparatively, the industry’s “law” defends a regime of liberated information access.

An augmented ability to control and influence the field of medicine hinges on how state modalities frame and filter the issue, and produces formalized outputs. Beyond the modalities alluded to in prior chapters are mechanisms through which an official realism is given to the working conception “physician privacy”. This chapter examines levels of pronouncement by state mechanisms like privacy commissioners, legislators, and the courts – in terms of their contents, as well as their underlying investigation and decision-making processes. The chapter also discusses the role of medical associations

and physician advocacy groups as modalities that are, by nature, external to the State yet instrumental in the realization of the notion's officiality. They are spaces in which the medical profession's ideals can mature and develop into policy recommendations and other lobbying manoeuvres. Lastly, the chapter briefly overviews the pharmaceutical industry's adjustment to state pronouncements and other forms of physician resistance to protect its marketing ability – thus illustrating the on-going nature of the physician privacy issue.

STATE PRONOUNCEMENTS: WHERE THE LINES ARE DRAWN

State mechanisms exercise power depending on the manner they are called upon to act, frame, assess and rule on the issue of physician privacy. By clarifying the boundaries of (il)legality surrounding the issue, these mechanisms exercise power by affecting the field of possible actions that the medical community and the pharmaceutical industry can take to pursue their desired “law”.

To illustrate how this field is shaped, I look at the involvement of Frank J. Work, former Information and Privacy Commissioner of Alberta. On March 19, 2003 he issued a report regarding the data-mining practices of IMS Health Canada.⁷¹ Enabled by the provincial *Health Information Act* (“HIA”), the Commissioner conducted an investigation to determine whether the practice of disclosing physician prescription information to IMS Health Canada – by Alberta pharmacies and pharmacists – complies with the HIA (par. 3). Following a public hearing, he found that pharmacies and pharmacists were disclosing up to thirty-seven data elements regarding physicians' prescribing activity without their consent.⁷² Based on his interpretation of the HIA in light of these findings,

the Commissioner issued an order prohibiting pharmacies and pharmacists from disclosing data elements without physicians' consent.

As a modality, the Commissioner exerted power over the operations of pharmacies by issuing an order under the HIA. While the power is rooted in the order itself, in terms of its effect on *how things ought to be done* in subsequent information transactions, the power fundamentally lies in the establishment of an understanding of privacy that stems from the Commissioner's interpretation of the HIA. By projecting the Act's language onto the situation at hand, he not only delineates an understanding of "privacy" but also an understanding of "health". In the process of assessing the illegality of the practice, for instance, the Commissioner found that "prescribing" was considered a "health service" under the legislation; that a prescriber was considered a "health services provider" (par. 29); that the first and last name of the "health services provider" were considered "health services provider information" (par. 43); and that the disclosure of this information alongside the other thirty-five data elements would reveal "other information" about said "health services provider" (par. 58). While these interpretive associations confirm the Commissioner's jurisdiction to rule on the issue, they also delineate a field of actions and actors that properly *belong* to the sphere of health care provision. These delineations also emerge from the Commissioner's responses to counter-arguments put forth by IMS Health Canada. One argument maintained that certain professionals could not be considered "health services providers" under the HIA given that they are not providing a "health service" if their prescribing services are not paid for by the Department of Health (par. 34). It proposes a different sphere of belonging in health care provision that challenges the professional capacities of doctors

based on the extent to which they serve the State. In response, the Commissioner reconfigured the proposed sphere by stating that “[a] prescriber gets paid by the Department for a visit in which the prescriber gives professional advice, which includes prescribing” (par. 38). Prescription-writing can be deemed a health service if it is part of the professional advice provided to a patient for a purpose among those stipulated in the HIA. The Commissioner further supported his response by explaining the consequences of adopting IMS’ counter-argument:

The argument that prescribing does not fall within a “health service” would result in a strained regime in which a physician who prescribed an antibiotic for a sick child would not be providing a “health service” to that child in so far as the prescription was concerned. However, a pharmacist filling that prescription would be providing a “health service” to that child, regardless of how the service is paid for, under section 1(1)(m)(ii) of the Act. This cannot be what the Legislature intended (par. 39).

The view that doctors are not “health services providers” is a surprising one, given that is it counterintuitive to the common understanding of what doctors do. Their function as providers should be self-evident and yet it was contested through the meaning of the HIA. The Commissioner’s interpretation thus clarifies the professional status of doctors in light of the legislation, while addressing what falls within – and outside of – the sphere of health care. He asserts, for example, that IMS cannot be a “health information custodian” because of its status as “a private sector corporation that lies outside of the publicly funded health system” (par. 26). The statement shows a delineation of interests, and the degree to which these interests are entitled to the privilege of collecting, using and disclosing health information. The manoeuvrability the company typically enjoys within the system to commodify physician-linked information, its *belonging* in health care in other words, is therefore redefined.

The delineation is further realized when the Commissioner compares the HIA with the applicability of other federal and provincial privacy legislation to the issue. The comparison focuses on the definition of “personal information” in both PIPEDA and Alberta’s *Freedom of Information and Protection of Privacy Act* (FOIP):

In making this determination under sub-issue D [whether the disclosure of the information items reveals “other information” about physicians], I did not accept the interpretative arguments that relied upon PIPEDA or the FOIP Act. A review of the definitions section of PIPEDA (section 2) shows that “personal information” is defined as “information about an identifiable individual, but does not include the name, title or business address or telephone number of an employee or an organization.” PIPEDA’s master category, personal information, is unlike the definition of health information, and health services provider information, in HIA. As for the argument that I should read the phrase “other information” in section 37(2)(a) as “other personal information”, looking to the language of the FOIP Act, I do not agree. The language of section 37(2)(a) is sufficiently clear and unambiguous for me to stay within the corners of the HIA. Moreover, the FOIP Act and the HIA deal with similar, but not identical, types of information within the public sector. The FOIP Act and the HIA have similar, but not identical, objects. I find it significant that the Legislature decided to carve “health information” out of the realm of the FOIP Act’s definition of personal information, and create a stand-alone Act that does not use the FOIP Act’s concept of “personal information”, but instead employs a *distinct concept*, that of “health information” (emphasis added; par. 80).

The Commissioner establishes that “health information” relates directly to the types of information at issue, physician prescription information, and not open to broader interpretations enabled by the FOIP Act or PIPEDA. The assertion that physician information cannot be interpreted generally, and risk falling into a “work product” categorization, draws a legal boundary between health care institutions and other actors that are defined by a divergent profit-oriented *raison d’être*.

In making this distinction, the Commissioner also defines the alleged privacy infringement as a phenomenon that involves a spectrum of players in medicine – beyond IMS Health Canada and physicians. This is illustrated in the *Notice of Investigation* and *Oral Public Hearing* issued by the Commissioner’s Office on January 22, 2002. Not only

was it issued to the attention of all pharmacies, pharmacists and doctors in Alberta (par. 4), but to the attention of the Alberta College of Pharmacists, the Pharmacists' Association of Alberta, the Canadian Association of Chain Drug Stores, the National Association of Pharmacy Regulatory Authorities, the College of Physicians and Surgeons of Alberta, the Alberta Medical Association, Alberta Health and Wellness, as well as IMS Health (par. 5). All aspects of the Alberta health care system were made aware of this issue through a disseminated network of public advertising. The Notice was first communicated to the above organizations who, in turn, communicated summaries to their members through fax or on-line postings (par. 6). It was also communicated to the public through several local newspapers such as the *Edmonton Journal*, the *Edmonton Sun*, the *Calgary Herald* and the *Calgary Sun* (par. 7). This call for input presumed that each player may have something to say on the issue, as though each were part of a wider field of shared responsibility contributing to the existence data-mining practices.

Though the Commissioner's final order takes aim at pharmacists and pharmacies as facilitators of IMS' practices, by implicating an extended spectrum of actors, a socio-political significance is given to the issue. The Commissioner, in *what* he does and the approach he uses to decide *what* is officially stated, establishes interpretational parameters that shape the field of power relations between the parties. His statements and approach equally unlock languages that highlight the uniqueness and importance of health information that is built into the HIA.

As a modality of power, as an ombudsman, he is his own discourse. The Commissioner's involvement forms part of an overall effect of power – an emerging trend of denouncement against data-mining – which has prompted the industry's

subsequent adjustment of its presence in health care. This trend is emerging differently in the U.S., with the state legislatures of Maine, Vermont and New Hampshire (thus far) having pronounced on the data-mining issue by passing laws that restrict access to physician-identified prescription data.⁷³ New Hampshire was the first state to approve this restriction in June 2006 with its *Prescription Confidentiality Act*, which was intended to contain health care costs by removing the ability of drug sales staff to influence physicians' prescribing habits (*Concord Monitor*, 2007). To challenge the law, lawyers representing IMS and Verispan (another market surveillance firm) argued that it violated their First Amendment rights to free speech. The sharing of prescription data among pharmaceutical companies and data-mining firms, they maintain, cannot be deemed a "marketing activity" because the data is not commercial in nature. What is being shared, rather, is "truthful information that lawfully is in their possession" (Herskovits, 2006). According to IMS the activity facilitates a central goal of "maintaining greater transparency and the free flow of information in the U.S. healthcare system."⁷⁴ In April 2007, Federal District Judge Paul Barbadaro struck down the New Hampshire law on the grounds that "there was no legitimate privacy interest involved" nor substantial evidence that drug sales representatives harass physicians, nor any evidence that the data "is being used to propagate false or misleading marketing messages."⁷⁵

Along similar lines, a preliminary injunction was issued against the Maine statute by Federal District Judge John Woodcock in December 2007. Agreeing on the importance of transparency in health care, he found that physician-identified information is "not simply useful; it is valuable."⁷⁶ In a similar manner, on November 23, 2010, the U.S. Court of Appeals for the Second Circuit in New York overturned the Vermont law.

Judge John G. Koeltl found that the law “is a commercial speech restriction that does not directly advance the substantial state interests asserted by Vermont” (Ringler, 2010). The Vermont Attorney General’s Office responded by filing a petition to seek the U.S. Supreme Court’s review, and released a press release on January 7, 2011 announcing that the court agreed to hear the case, *Sorrell v. IMS Health Inc.*, No. 10-779 to decide the constitutionality of the law. The case is expected to be decided in June 2011.⁷⁷

Though data-mining companies are stalling the effect of such laws, other state attorney generals are challenging the grounds upon which the constitutional infringement is claimed. New Hampshire Attorney General, Kelly Ayotte, for instance, appealed the U.S. District Court’s decision to the 1st U.S. Circuit Court of Appeals in August 2007 (O’Reilly, 2007). The appeal was fruitful and the decision was overturned. Yet the Court of Appeals did not do so by opting for the state’s position but by critiquing the arguments put forth by the Attorney General, as well as those made by IMS and the prior court to strike down the law. Its ruling, in other words, revealed a dissatisfaction in the manner in which the issue was framed and proposed another understanding of the issue. First, it found that IMS and Verispan did not have legal standing to sue the state legislature on behalf of pharmaceutical detailers for the freedom of speech infringement. It maintained that “data miners must assert their own rights and explain how those rights are infringed by the operation of the Prescription Information Law” (*IMS v. Ayotte*, p. 16).

Like the Alberta Information and Privacy Commissioner, the court delineated a sphere of belonging which prevented data-mining companies from pursuing their interests as freely as they did before. The court drew another boundary when it found that First Amendment rights protections were inapplicable given that the intent of the New

Hampshire law was to regulate conduct as opposed to speech. If a pharmaceutical company uses prescription data to identify preferred physicians for the purpose of swaying their prescribing tendencies, such a use is deemed conduct – it does not constitute speech.

We say that the challenged elements of the Prescription Information Law principally regulate conduct because those provisions serve only to restrict the ability of data miners to aggregate, compile, and transfer information destined for narrowly defined commercial ends (p. 22).

The case had incited a range of concerns regarding the law's consequences for free speech, free market values and patient care. Yet the Court of Appeals chose not to pronounce on all these concerns, nor did it specifically augment the status of physicians and their privacy rights over the industry's claims. It merely re-framed the issue with its "speech or conduct" specification, thus dismantling IMS and Verispan's grounds for challenging the law. The pronouncement raises a wall in the path of their pursuit, which demands a more relevant type of argument in order to successfully challenge the law – a law the court maintains is "innovative" policy for coping with the challenges of controlling health care costs (p.3). The trend persisted in another ruling by a federal district court which upheld the contested Vermont law. U.S. District Judge J. Garvan Murtha maintained that the state had successfully demonstrated that drug-detailing "encourages doctors to prescribe newer, more expensive and potentially more dangerous drugs instead of adhering to evidence-based treatment guidelines" (O'Reilly, 2009).

Though the issue of physician privacy seemingly moves through U.S. mechanisms differently from its development within Alberta-based mechanisms, each example illustrates how built-in state modalities set parameters that contain the manoeuvrability of data-mining companies. Their pronouncements influence how doctors,

pharmacists, pharmaceutical companies and market surveillance companies necessarily think and debate the issue of privacy. More broadly, they shape the field of possibilities where different visions of health care interact and compete against one another.

To link these pronouncements to their roots in the social power of medical expertise, I briefly look at a second category of modalities through which physicians *acquire a voice* and call upon the engagement of state mechanisms. These are forms of physician mobilization – medical associations and think tanks – that, although external to the state structure, are themselves independent self-governing state-like entities. Within these areas of mobilization, ideals of health care provision are fostered and subsequently materialized into policy recommendations. The manifestation of such ideals eventually contributes to the languages of regulatory instruments such as Alberta’s *Health Information Act* and New Hampshire’s *Prescription Information Law*, which form the basis of the emerging “law” on physician privacy.

MODALITIES FOR MOBILIZATION

One type of space is enabled by medical associations. As state-like structures, they serve a regulatory function over members through established standards of conduct, codes of ethics and policy guidelines. They also serve an “official representation” function for the profession in its interactions with government, media and associated sectors involved in health care provision. Both functions entail networking processes – conferences, on-line advocacy discussion groups – that facilitate dialogue on a range of subjects from clinical best practices to health care policy. To reconcile an array of health care ideals and positions held by their membership, medical associations naturally embody a different microcosm of power relations relative to their concern with “physician privacy”. These

ideals are inevitably melded into official positions that may regulate the membership and partake in a lobbying effort to shape government policies.

Whereas state mechanisms typically undergo a broad evaluation of legal, social, political, economic and professional considerations to establish a “law” on medical information privacy, medical associations generate policy outputs that more narrowly suit the profession’s ideal “law”. In the circumstances surrounding the Alberta Information and Privacy Commissioner’s involvement, for instance, it was the Alberta Medical Association that lead the mobilization of resources needed to contest data-mining practices, with its staff and legal counsel spending “months gathering information and preparing a brief for a two-day public hearing held in April 2002” (Dunleavy, 2003: 1169). In the context of the *Maheu* case, the Canadian Medical Association participated in PIPEDA’s review by the House of Commons Standing Committee on Access to Information, Privacy and Ethics in 2006. Dr. Bonnie Chan, the witness representing the CMA, expressed the association’s stance on PIPEDA’s protections. One sought after ideal is concrete legal recognition of health care’s uniqueness as a policy sector, that would counter the perception of prescription data as “work products”. The CMA therefore proposed a “legislative change to include physician information as personal information under PIPEDA” (p. 1535).⁷⁸

Privacy law, for doctors, would ideally give exception to health care as a field that requires its own specialized legal status to control the interpretation of issues. It would also embody the distinction between doctors and other health care professions. In a 2007 CMA convention, for example, members voted against a motion that would allow pharmacists to write prescriptions when part of a collaborative patient care team.

Justifying the vote, members felt that physicians “should lead such teams and prescribe medication because they’re adequately trained to take patient’s medical history, do a physical exam, order and interpret tests, and come up with a diagnosis” (CBC News, 2007). Another example is a recent CBC Radio report by Dr. Brian Goldman on the opening of a nurse practitioner⁷⁹ clinic in Sudbury to alleviate the demand for medical services. When asked how doctors were reacting to the emergence of these clinics, Dr. Goldman replied that:

[i]ndividual physicians don’t mind having nurse practitioners as colleagues. [...] But what is interesting is that organizations like the Ontario Medical Association aren’t quite so pleased. They don’t think that clinics should be run by nurse practitioners, they think that MDs – not nurse practitioners – should be the gatekeepers of the health care system...⁸⁰

Medical associations sensitize law-making institutions to the *apartness* of health care from other sectors upon which privacy legislation applies, while putting forth the finer specification that physicians represent the sole “gatekeeper” profession of this field. This sought gatekeeper status allows physicians to give the law to themselves. To this end, medical associations seek to empower by achieving greater controls over the conditions of the medical practice.

The positions they take and the manner in which they are pursued, however, are naturally met with disagreement throughout the health care community. Medical associations are criticized by their own membership for policies that compromise the effort to insulate the profession from aggressive marketing practices, thus motivating physicians to seek mobilization elsewhere. An example is the American Medical Association’s Prescription Data Restriction Program (PDRP). It was established in July 2006 to give an opt-out alternative to physicians who do not want their prescribing data disclosed to pharmaceutical companies (Rawson, 2007: 13). Companies, in turn, must

check the opt-out list every three months and comply with requests 90 days within their receipt. Physicians can also report inappropriate marketing behaviours through the PDRP. The AMA promotes the measure as “[a] path to protect prescribing data without drastic, unintended consequences” that may, for example, prevent the availability of prescribing data for health research purposes (AMA, 2008: 6). Interestingly, the brochure describes the PRDP as a solution developed by physicians that “puts the opt-out choice into the hands of physicians – the professionals most qualified to make informed decisions” (AMA, 2008: 5). Nevertheless, some physicians view the program as a weak compromise that benefits the companies in the end. According to Whitney (2006), the pharmaceutical industry supports the program based on the hope that its success neutralizes the political activism of physicians and state legislatures. If there are enough physicians who opt out, outcry is expected to decrease and state legislatures will respond accordingly by focusing on other health care issues. Furthermore, the PRDP’s very existence enables the surveillance of physician (dis)satisfaction and informs the industry on how it can adapt to establish a more productive relationship with doctors (Rawson, 2007: 15). Though the PRDP can empower physicians to withdraw from the data-mining process, it is criticized as a stalling tactic.

The AMA has drawn other criticisms given that it sells its Masterfile to drug companies and data-mining companies, which is matched with pharmacy databases to render prescription data physician-identifiable. According to Mullin (2007), the AMA earned nearly 44.5 million USD in 2005 in sold Masterfiles.⁸¹ The AMA thus plays a central role in the vulnerability of physician privacy and other issues tied to the profession’s entanglement with the pharmaceutical industry. In doing so, the AMA’s

presence carries a proliferation of alternative means through which dissenting physicians can pursue their ideals. An example is *No Free Lunch*, a New York-based not-for-profit organization comprised of “health care providers who believe that pharmaceutical promotion should not guide clinical practice”. Through its awareness-raising activities, it aims to guide medicine towards “scientific evidence” as opposed to “pharmaceutical promotion”.⁸² Another example is the *Prescription Project*, an initiative based in New York and Boston that addresses conflicts of interests associated with drug marketing tactics. It similarly encourages change across medical institutions by sponsoring “research and policy analysis; national and community-based forums; outreach to the media; and meetings with key decision-makers, including deans of medical schools, health care administrators, business leaders, policymakers and consumers.”⁸³ The Internet and interactive blogging enable the proliferation of these spaces which, in turn, foster an underlying notion of “physician privacy” in a way that is not stagnant and isolated from other health care issues – but integral to physician empowerment.

The modalities together form a spectrum of activism and representation of the tensions experienced within the medical community, among related professions and among physicians themselves. The envisioned “law” on physician privacy is channeled through these different spaces, and their respective manners of framing the issue, as well as the battles they choose to achieve their respective objectives. Such modalities are therefore sites of discourse that may thrive, or be marginalized, in the arenas of policy- or law-making.

Modalities for mobilization are also observable in the pharmaceutical marketing industry. Like medicine, the industry faces declining public sentiment, fuelled in part by

media *exposés* of ineffective or potentially harmful pharmaceutical products.⁸⁴ This view surfaces in an article from *Ipsos Insight* published in 2004 regarding the effectiveness of pharmaceutical advertising:

The level of consumer response to direct-to-consumer advertising has been steadily declining since 2002 and is expected to continue eroding in the wake of the abrupt recall of blockbuster drug Vioxx, according to new findings from Ipsos PharmTrends, a syndicated tracking study of consumer behavior by Ipsos, the global survey-based marketing research firm.⁸⁵

The public's growing awareness of elaborate marketing tactics and elevated drug pricing contribute to cast doubt on the industry's commitments to social responsibility and sound clinical research. Such trends carry economic consequences according to Janet Woodcock, Associate Commissioner of Operations at the U.S. Food and Drug Administration, who remarked that "[t]he 90s-era model of drug development is not going to be sustainable" (Rawson, 2007: 9). Furthermore, a survey conducted by the Association of the British Pharmaceutical Industry in 2008 found that 35% of the British manufacturing firms polled were expected to cut their research and development investments over the next year, while 46% were expected to conduct fewer clinical trials. The findings anticipate declines in collaborative research projects with British universities as well.⁸⁶

These outcomes are not entirely due to waning public confidence. Some sources point to an increasingly competitive global marketplace, with the emergence of Asian economies for instance, as a key factor.⁸⁷ On many counts, the commercial momentum of the pharmaceutical industry has decreased and has therefore adapted accordingly through its own modalities of influence. Companies like IMS and Verispan have combined their legal resources to prevent the outlawing of data-mining practices among American states. In the case of New Hampshire's prescription information law, it is apparent that one of

the fronts is to pursue a “final say”, a more definitive legal boundary on data-mining that favors the pharmaceutical industry. Following the U.S. Court of Appeals First Circuit ruling in *IMS vs. Ayotte*, IMS and Verispan filed court papers to the U.S. Supreme Court with hopes of blocking the law’s enforcement until it is determined whether the court wants to hear an appeal (*Associated Press*, “NH prescription privacy law at high court”, 2009). The court’s response could set a precedent that deters U.S. states and jurisdictions around the world from developing similar prescription information laws. On June 29, 2009, however, the Supreme Court declined the review request – thus the New Hampshire law remains in effect.⁸⁸

Given the implications of these legal outcomes, data-mining companies are expected to continue their mobilization of legal and political resources in an attempt to control the dialogue with law-making institutions. Nevertheless, not all modalities are adversarial in their method and desired effect. The industry’s ability to adapt lies in modalities of compromise with physician groups, as illustrated with the aforementioned Physician Data Restriction Program established by the American Medical Association. In 1996, a similar policy was initiated by IMS Health Canada which gave physicians the opportunity to request that their prescription information not be sold to pharmaceutical companies. The policy was revoked in 2003 when the number of opt-out requests had increased beyond the company’s estimation – due to a letter forwarded to members of the Alberta Medical Association urging doctors to take advantage of the policy (Sibbald, 2003b: 1066).

Such modalities, in the end, illustrate the discursive nature and unrelenting continuity of the industry’s pursuit for commercial growth. According to IMS company

director Robert Hunkler, limits on data access “will not stop pharmaceutical marketing” (Saul, 2006). Though marketing firms, for example, previously circumvented patient privacy by accessing physician-linked data, the industry is now revisiting the possibilities of mining and matching patient data (Morris *et al.* 2004).⁸⁹ “Patient-level data” is de-identified, consisting of a combination of medical information items extracted from processed medical insurance and pharmacy claims that enable comprehensive analyses of a patient’s treatment experiences over time (Morris *et al.*, 2004: 13-15). The enabling resource, the type of data and the methodology used to match data sources, is thus adapted according to the emergence of limitations on the industry’s manoeuvrability. Yet the objective remains the same: “to improve promotional programs, sharpen messaging, refine segmentation, and enhance product and brand performance” (p. 16).

This trend is fuelled by the recent mobilization of academic experts within the data-mining community, who seek to improve their science so as to side-step regulatory challenges and meet growing information demands. For these experts, it is a refined art to know more about a given subject in such circumstances. The *expertise* of data-mining is displayed in competitions like the Knowledge Discovery and Data Mining Working Group of the American Medical Information Association (AMIA). It is held as an annual challenge and a sharing exercise for leading scholars around the world. Though they are typically given a specific public health area of study, such as National Health and Nutrition Examination Survey data-set for the 2008 competition, the methodological advancements arising from these competitions undoubtedly feed into any industry’s capacity to target its market successfully.

PHYSICIAN PRIVACY: A MODALITY IN ITSELF

For the data-mining industry, and the pharmaceutical industry, the modalities of mobilization seek an optimal regulatory environment in which consumer profiling of the patient or the physician is permitted. The modalities differ from those observed in the physician community, where particular ideals (and the language to support such ideals) gain a voice depending on the variety of the spaces that form within the community. The nature of the mobilization varies depending on the desired vision of medical practice and health care services delivery, and its place on a spectrum of ideals regarding the sought proximity – or level of entanglement – the profession ought to share with the industry. The heterogeneity of mobilization types, as such, reveals the fundamental difficulty of establishing unanimous agreement among doctors regarding their professional identity.

By looking at the modalities of mobilization, this analysis deepens the context surrounding the making of an official privacy law by state mechanisms. It is through mobilization that the concept emerges more clearly as a phenomenon rooted in the sociology of expertise. “Physician privacy” expectedly became “real” when the professional identity of physicians was at risk of losing itself to an uncontrolled series of influences enabled by data-mining practices.

This heterogeneity of modalities has produced a series of sound-bites and ideas that, however disjointed and inherently complex as a whole, have contributed to the involvement of state modalities towards the concretization of “physician privacy”. Whether an ombudsman, a legislature or a court, these centres inevitably make law in the manner that they frame the issue and draw boundaries on data-mining – in accordance to their enabling law-making powers. Such law, in turn, continuously feeds back into the

various aspects of the dialogue within the health care community. The issue has acquired different levels of concreteness over time due to these modalities, which tend to broadly associate it with other issues in medicine. The form and movement of the issue carry dispersed power effects upon the industry's marketing capacity. One could argue that the doors are *closing in* on the industry's ability to influence its own regulatory environment, given the growing sentiment that its technologies should be better controlled through legislation and court activity. Yet there remains the question as to whether the cumulative effect of this sentiment and legal instrumentation can keep up with the speed with which the industry is side-stepping the resistance. Physician privacy discourse informs us about the existence of the issue and its roots, but there is a lack of follow-up discussion as to whether the industry is successfully being deterred from influencing medicine. Nor can I accurately determine – in the context of the present study – that whatever protections granted to physicians thus far, necessarily satisfy their privacy needs.

In other words, it is not clear from the analysis of these modalities whether a true “winner” or a “loser” emerges. Rather, I have broadly sketched the ways in which physician privacy is a modality in itself to communicate the status of medicine as a field of practice, and physicians as those who master the field itself. By authoring the notion itself physicians can, at least, draw attention to the marketing apparatus and its subjectification of physicians – with hopes that the notion can strengthen the profession's ability to control the risks arising from its relationship with pharmacology. With the recent cases of adverse drug reactions, notably the fatalities caused by the anti-inflammatory drug Vioxx⁹⁰ and the cholesterol-lowering drug Baycol,⁹¹ physician privacy not only addresses the intrusiveness of sales tactics upon medical decision-

making, but also serves to control the spectrum of legal and social consequences that physicians face when held accountable for harmful pharmaceutical products.

In a connected manner, the issue acts as an avenue through which theoretical commentary regarding “good medicine” – and how doctors ensure such a notion – can progress. Though it remains unclear what this ideal consists of, one of its underlying elements is the containment of the pharmaceutical industry to ensure that profit-oriented motives do not guide or limit the system’s scope of care. Again, there are varying opinions as to the actual level of containment that is desired, but what is apparent from emerging medical privacy law is that the issue, in its own way, is urging the clarification of this ideal. Data-mining has prompted medicine to react and pronounce itself regarding the industry’s reach into the daily and mundane, yet significant, aspects of its practice. These informal reactions and legal responses for a desired level of containment seem to be threaded together by an underlying philosophy of health care provision. It is a political investment choice, or a choice between different wielders of power: whether the industry is justifiably capable of being entrusted with free and unimpeded access to consumer information about physicians and patients, or whether such investments should remain in the hands of the classical profession – where doctors *know best* on the necessities of a functioning health care system.

Debates on physician privacy inevitably bring this choice a little closer to the surface of overarching questions and concerns regarding the manner in which medical expertise is authored, and how these different claims to authorship should translate into an ability to shape health care. However, the real question is whether “physician privacy” was an effective modality in increasing the profession’s control over its socio-political

status – and the degree to which this control increase is achieved. In the following conclusion, I address the gains and losses of the notion's usage in the experience of physician mobilization, in terms of how discourse and action are fundamentally affected by the notion's troublesome philosophical roots.

Conclusion

When I initially prepared the layout of this thesis, the issue of physician privacy represented an opportunity to witness the collision between commercial interests and public interests. It represented an opportunity to see physicians “in action” with regards to the management of the circumstances of their profession’s practice, and to determine the social and political parameters of this activism.

The context analysis in Chapter 1 certainly provided evidence that the conditions were “ripe” for resistance efforts. The discourse analysis found patterns in physicians’ reaction to the methods and purposes of commercial data-mining, that confirm the significance of the issue relative to the range of power – therapeutic, political and social – enabled by the physicians’ gatekeeper status. The statements analyzed in Chapter 2 arguably point to an underlying notion of (in)justice tied to the manners in which prescription data is collected and subsequently used.

Beyond these findings, it is difficult to determine the extent to which “physician privacy” is framed as a central tenet for the profession’s recent lobbying efforts to control the pressures exerted by the pharmaceutical industry. More evident is the issue’s downturn in terms of the frequency and depth with which it is discussed in mainstream and academic literature. The issue has regressed into a pool of general information technology concerns regarding the accessibility of patient health records to public authorities and private companies, including internet heavyweights like Google – as well as concerns over the impacts of social networking websites in health care.⁹² The pursuit for “physician privacy” as an independent policy goal seems to have stalled since the issue reached its “fruition” through the delineations established and upheld by

legislatures and courts explored in Chapter 4 – with some delineations still pending (i.e. the Vermont law).

This downturn may be due to the fact that “physician privacy” was reluctantly conceived and developed as a stand-alone notion. It emerged in this manner given that physicians would inevitably encounter the conceptual malleability of general “privacy” which would, in turn, require a complicated tailoring process in order to specialize their information-control needs. For the notion to reach its “fruition” in the courts and legislatures, in other words, it had to be a notion that was contained within the ambiguous language of privacy rights – yet the complete grasp of the injustice underlying data-mining is arguably lost in the ambiguity of rights language itself as well the *ex post facto* nature of privacy demands.

It takes an analytical approach concerned with the knowledge-power interplay to explain the fundamental relevance of “physician privacy” to multiple aspects of the relationship the medical profession shares with the pharmaceutical industry. The study of discourse and the dimensions of a surveillant discipline clarifies the issue, with the finding that data-mining enables a particular gaze that reduces medical expertise into a science of calculable commercial transactions. Throughout Chapter 2 and Chapter 3, it becomes increasingly evident that the problem with data-mining is not about “privacy” *per se* but specifically concerned with the ways in which the shifting power dynamic between physicians and the pharmaceutical industry is manifested politically and socially. The concern that underlies “privacy”, I have argued, is one regarding the implications of the industry’s gaze on the medical profession. By the end of the analysis, “privacy” may appear to be a successful avenue for yielding a legal effect on the conditions of the

medical profession – but only narrowly. The added gain of applying a Foucauldian approach is a more nuanced problematization of the physician-industry relationship. In doing so, I found that the mobilization potential of “physician privacy” is not only limited by its dependence on a language of privacy rights, but also limited by the divisions within the physician community as to its perceptions of how data-mining ultimately affects the profession and its ability to shape its own field of expertise, or even its ability to control the degree to which commercial interests can be authoritative in health care.

Foucault’s power-knowledge conception demands that the dynamic *not* be framed as a two-sided boxing match between physicians and the whole of the pharmaceutical industry, including its interrelated marketing components. Foucault’s attention to the granularity of power enabled me to paint an ordered and purposeful surveillance system towards increased drug consumption, rooted in profiling grids and detailed salesmanship protocols borne out of an expertise about doctors. This depiction of opposing forces between the subject and the subjector, however, can only be made possible if it accounts for the ways in which the parties are not dichotomous to one another nor engaged in one’s repression of the other. In *Truth and Power*, Foucault (1980) elaborates on the inadequacies of an approach that solely hinges on a notion of repression:

What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (p. 119).

His analyses of prisons, psychiatric institutions and sexuality ultimately sought an understanding of power in terms of a full spectrum of micro-relations underlying an individual’s responsiveness to an exercise of influence – or an individual’s willingness to conform. Likewise, the complication of explaining *why physician privacy matters* is the

reality that physicians and the pharmaceutical industry have – in colloquial terms – grown up and lived comfortably together in health care systems for centuries. Their respective histories are intertwined such that the industry’s presence forms part of a “way of life” in medicine today (Moynihan and Cassels, 2005: 5). One, just as much as the other, gains from this closeness: the industry surviving commercially through its contributions to medical expertise, and the profession increasingly depending on the pharmaceutical industry for research funding, and the innovation of treatment and diagnostic approaches.⁹³

Jerome Kassirer’s (2005) commentary in the *Journal of Public Health Policy* discusses the flagrant side of these relationships, or as he refers to it, a “circus atmosphere”, typically consisting of gift-giving and off-label drug promotions at “educational” meetings hosted by professional societies. For Kassirer, it is important to look beyond the disapproval of these manifestations, no matter how flagrant they may be, and reframe the discussion in a different manner: “The issue is what these relationships signify for the validity of the functions of the professional organizations, including education, public advocacy, and the validity of synthesized medical information” (p. 401). Such “circus atmospheres” mean nothing if they are not explored within the context and consequences of the industry-profession relationship. In a similar manner, the true significance of “physician privacy” – or any privacy issue for that matter – would be shortchanged if it were not couched within the complexities of this relationship.

Although there is little doubt that privacy is “loaded” in this case, by inadvertently exploring a *relationship* my analysis produces two interesting aspects of “physician privacy”. One is packaged by its own officiality and closed-in by its requests for greater

controls over prescription data as a primarily legal space, and the other is an underlying argumentative space that remains open-ended and may be enhanced by broader philosophical discussions on power and surveillance. This second understanding would not be a stand-alone notion that eventually gets lost in a host of other lobbying efforts, but a perspective that acts as a connective frame for an array of efforts to regulate the industry-physician relationship. Whether it is controlling the role of the pharmaceutical industry in medical schools,⁹⁴ regulating direct-to-consumer advertising,⁹⁵ or establishing restrictions on drug salesmanship (i.e. gift-giving), each of these manifestations partake in the same knowledge-power interplay from which “physician privacy” emerged.

Despite this reality, it is nearly impossible to find literary works that inventorize these issues, by taking stock of the complexity inherent to each issue, and spell out the ways in which they are connected. As mentioned in Chapter 1, there is no shortage of insightful writings about the pharmaceutical industry and the relentlessness of its profit-centered business – as an “other”. Nor will there be a shortage of analyses that conceive such issues as “argumentative spaces”. The shortage lies in the understanding of the relationship itself and the multiple ways in which doctors participate in the manifestation of this relationship.

Not only would such works enable an understanding of how the validity of the functions of professional organizations is necessarily affected by their relationship with industry (in Kassirer’s terms), these works would be a significant display of the profession’s ownership over expertise *about* itself – and may benefit physicians in an era of public scrutiny and doubt.

Appendix A: IMS advertisement

Source: Product Management Today (2006), Vol. 17(9), p. 14.

Appendix B: CMA Statement of Principles: The Sale and Use of Data on Individual Physicians' Prescribing

CMA POLICY

STATEMENT OF PRINCIPLES: THE SALE AND USE OF DATA ON INDIVIDUAL PHYSICIANS' PRESCRIBING

The CMA believes that prescribing data that identify individual physicians should be used in a manner that does not breach the privacy of patients or of physicians in their personal or professional lives. To address this concern, the CMA has developed the following set of principles for the compilation, sale and other commercial use of data on individual physician prescribers.

Private health-care-information companies have been purchasing data on prescriptions filled at pharmacies, analysing the data and producing profiles of individual physicians' prescribing patterns, which are sold to drug manufacturers. It is claimed that patient identity is protected from disclosure during this process. However, some pharmacies provide the physicians' identity to allow individual profiles to be developed. This situation is a symptom of a much broader issue. A general set of principles governing the sale and use of data on individual physicians' prescribing is clearly required.

The CMA recognizes that pharmacists must collect prescriber data for governmental and certain nongovernmental use. This practice is sanctioned by law and is not the subject of this statement of principles. However, this statement does apply to the use of these data for purposes other than the purpose for which

they were originally collected.

The Issue

Prescribing data that identify individual physicians and that allow profiles to be constructed have been compiled and sold without physicians' consent. Until news of the practice became public in March 1996, most physicians were unaware that identifying information about their prescribing was being compiled and disclosed to third parties. The invasion of physician privacy raises major ethical and legal concerns for the medical profession.

CMA believes that data that identify individual physicians should be compiled or used only in an ethically and legally appropriate manner that does not breach the privacy of patients or of physicians in their personal or professional lives. Furthermore,

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All policies of the CMA are accessible electronically through CMA Online: www.cma.ca.

Appendix B: CMA Statement of Principles: The Sale and Use of Data on Individual Physicians' Prescribing (continued)

the CMA believes that the ethical framework for any compilation and use of prescribing data that identify physicians should be based on public benefit and quality of care. If used appropriately as an educational tool, data on physician prescribing can have benefits for physicians and their patients. They can enhance the quality of care through the identification of learning needs and the provision of feedback to practitioners. Greater value could be gained if other information about the physician's practice characteristics and patient characteristics were compiled and compared with the prescribing profiles.

The Principles

Whereas the compilation and use of prescribing data can significantly benefit and harm physicians and their patients, the CMA encourages adherence to the following principles in order to maximize the benefits and minimize the harm.

1. **Data on individual physicians' prescribing must be compiled, sold or otherwise used in a manner that does not compromise the privacy of patients or physicians; anonymity and confidentiality must be maintained.**
2. **Except as authorized by law, physicians must be informed of, and their prior consent obtained for, the compilation of prescribing data that identify them and the sale or other use of such data. The consent obtained must be informed, positive, documented and time-limited. For greater certainty, the right of physicians to consent also includes the right to restrict or to refuse to allow the compilation, sale or other use of identifying information about them.**

The Supreme Court of Canada (*McBrien v MacDonaid* [1992] 2 SCR 138) has recognized that the medium on which patient information is recorded (the medical record, microfiche, electronic soft copy or other format) is owned by the individual or institution that compiled the information. However, the Supreme Court also drew a critical distinction between ownership of the physical record and ownership of, or beneficial interest in, the information contained in that record. The issue of ownership of the physical record is therefore extraneous to the legal status of, and protection accorded to, the information in the record.

Not all Canadian jurisdictions have specific privacy legislation governing information collected and used in or by the private sector. Furthermore, there continues to be debate over whether prescribing data that identify the prescribing physician and similar data should be treated as confidential and therefore subject to legal protection.

Despite uncertainty about the legal status of the data, it is the position of the medical associations that prescribing data that identify the prescribing physicians, whether defined as personal or professional, should be treated as confidential, with all of the ethical and legal safeguards in place. Release of the data can be a significant invasion of privacy. From the data, one can deduce physicians' location, income, personal preferences and other very personal attributes. Although the data are valuable in assessing certain aspects of physician performance, there is great potential for misuse. Inappropriate conclusions about the performance or the learning needs of a physician may be drawn from limited data. Use of the data in this respect must reside with the physician and those in whom he or she has confidence. Consequently, unless legally permitted or required, data that

Appendix B: CMA Statement of Principles: The Sale and Use of Data on Individual Physicians' Prescribing (continued)

identify prescribing physicians should not be compiled, sold or otherwise used without the knowledge and consent of the individual physicians concerned. This approach is in keeping with the Quebec privacy legislation governing the private sector and with the requirements in the *Guidelines on the Ethics of Relationships Between Pharmacists and Pharmaceutical Manufacturers* of the Canadian Pharmaceutical Association, which state that "information concerning patients' drug utilization and compliance *may* be shared with the drug's manufacturer, at the discretion of the pharmacist, *provided* patient and prescriber confidentiality is maintained." The national trend in business and other sectors is toward strengthening privacy protection, and steps should be taken to encourage and support this process in the health care sector as well.

The collection and use of physician prescriber data by governmental or regulatory agencies (e.g. for peer review or quality assurance) is outside the purview of this document.

3. **The primary purpose of compiling data on individual physicians' prescribing and developing profiles must be to provide individual physicians with an educational tool to enhance their prescribing practices and the quality of care provided to patients.**

Providing feedback on past patterns of practice, especially in conjunction with comparative data on ideal or peer practices, is an effective method of adult learning leading to appropriate changes in practice. Studies show that many physicians wish to practise according to recognized guidelines and often believe their practice is consistent with such guidelines, but they have no way of verifying this belief from actual data. Once the data are

provided, physicians can use them to ensure that their practices reflect such guidelines.

Once consent is appropriately obtained, the following principles also apply:

4. **Having compiled and analysed the data on individual prescribers, the compiler must make this information directly available, free of charge, to each individual physician concerned, along with appropriate data for comparison purposes. This information is an educational tool that physicians are encouraged to take advantage of to enhance the care they deliver.**
5. **Physicians must be provided with the names of any organizations that have been sold, or otherwise given access to, data about them.**

This sharing of information would put physicians on an equal footing with any representative of the organizations who may interact with the physician.

Appendix C: Corpus composition

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Appendix D: Inventory of marketing tactics

Table 1. Tactics for Manipulating Physicians

Physician Category	Technique	How It Sells Drugs	Comments
Friendly and outgoing	I frame everything as a gesture of friendship. I give them free samples not because it's my job, but because I like them so much. I provide office lunches. Because visiting them is such a pleasant relief from all the other docs. My drugs rarely get mentioned by me during our dinners.	Just being friends with most of my docs seemed to have some natural basic effect on their prescribing habits. When the time is ripe, I lean on my friendship to leverage more patient to my drugs. I say because it'll help me meet quota or it will impress my manager or it's crucial for my career.	Outgoing, friendly physicians are ever, reps favorite because cultivating friendship is a mutual aim. While this may be genuine behavior on the doctor side, it is usually calculated on the part of the rep.
Aloud and skeptical	I write the office with journal articles that specifically counter the doctor's perceptions of the shortcomings of my drug. Armed with the article and having hopefully scheduled a 20 minute appointment, the doctor escapes, I play dumb, and have the doc explain to me the significance of my article. The best mercenary docs are typically found further down the prescribing power scale. There are plenty of 6's, 7's, and 8's [lower prescribing doctors] who are eagerly mercenary but simply don't have the attention to devote to me. I pick a handful out and make them feel special enough with an eye towards the projected demand on my limited resources in mind. Basically, the common motif to docs whom you want to buy out is to closely associate your resource expenditure with an expectation—end. So doc, you'll choose Drug X for the next 5 patients who are depressed and with low energy? Oh, and don't forget dinner at Nobu next month. I'd love to meet your wife.	The only thing that remains for me to be just as persuasive enough to ask the doc to try my drug in situations that would not have been considered before. Based on the physician's own explanation.	Humility is a common approach to physicians who pride themselves on practicing evidence-based medicine. These docs are tough to persuade but not impossible. Typically, attempts at genuineness are only a marginally effective.
Mercenary	I pick a handful out and make them feel special enough with an eye towards the projected demand on my limited resources in mind. Basically, the common motif to docs whom you want to buy out is to closely associate your resource expenditure with an expectation—end. So doc, you'll choose Drug X for the next 5 patients who are depressed and with low energy? Oh, and don't forget dinner at Nobu next month. I'd love to meet your wife.	This is the closest drug reping comes to a commercial exchange. Delivering such closely associated messages crudely would be deemed insulting for most docs. A rep really has to feel comfortable about their mercenary nature and have a natural tone when making such suggestions.	Drug reps usually feel more camaraderie with competing reps than they do with their clients. Thus, when a doctor fails to fulfill their end of the prescription for dinners, bargain never gets around in the other rep's are less likely to invest resources in them.
High prescribers	I rely on making a strong personal connection to these docs—something to make me stand out from the crowd.	Friendship sells. The highest prescribers (9 and 10's) are ever reps sugar mommies and daddies. It's the equivalent of putting in the cash to try to buy these docs out. Because chances are, every other rep is falling head over heels to do so.	The highest prescribers receive better presents. Some reps said their 10's might receive unrestricted educational grants. I don't even restrict that they are the equivalent of a cash gift, although I did not personally provide any grants.
Prefers a competing drug	The first thing I want to understand is why they're using another drug as opposed to mine. If it's a question of attention, then I commit myself to having them with it until they're right. If they're convinced that the competitor drug is just better in some patient population, I frame my drug to either capture another market niche or, if I feel my drug could fare well in a comparison, I hammer its superiority over the competing drug.	It's during the course of conversation, the doctor says something that may contradict their limited usage of our product, then the rep will badger them to justify that contradiction. This quickly transforms the rep from a welcomed reprieve to a nuisance. It can be useful in limited circumstances. We force the doctors to continually explain their prescribing rationale, which tires some. Our intent is to engage in discourse but also to wear down the doc until he or she simply agrees to try the product for a specific patient profile for our drug.	For reps, this is a core function of our job. We're trained to do this in as subtle a way as possible. No doc likes to be told their judgment is wrong so the latter method typically requires some discretion.
Acquiescent doc	Most docs think that they simply agree that the rep is right. I cut out the rep by avoiding any conflict or commitment on my part. The samples and gifts they sent and having the encounter quickly. I think I could better inform them of the truth. The old adage is true especially in pharmaceuticals, there is much to be gained from this.	From the docs that my training has been taught to frame every prescription to ultimately derive commitments from my client with every discussion. Not that I'm not of my drugs superiority but I build the expectation to increase their usage of my product. They may offer a false promise but I'll know when they're lying. The presentation data is sufficiently detailed and computerized to affirm their behavior. It's almost like a hypnotic commitment in matter of a second. I've used the rep into a false sense of assurance. The docs are then called in for a conversational interview where they have to justify their previous quietness.	Gifts are used to entice a guilt and social pressure. Reps know that gifts create a subconscious obligation not to reprieve. No rep who doubts this from men need only see their doctor's presentation data or dining up at 5 to be convinced. Of course, many of the doctors think themselves immune to such influence. This is an illusion, reps try to maintain.

Appendix D: Inventory of marketing tactics (continued)

Physician Category	Technique	How It Sells Drugs	Comments
No-see/ No-time (hard-to-see docs)	Occasionally docs refuse to see reps. Some do it for ethical reasons, but most simply lack the time. Even when I don't manage to see the doctor, I can still make a successful call by detailing the staff. Although they're on the doc's side for the most part, it's amazing how much trouble one can rile up when the staff are lavished with food and gifts during a credible sounding presentation and then asked to discuss the usage of a drug on their patients.	It's a victory for me just to learn from the staff about which drugs are preferred, and why. That info provides powerful ammunition to debate the docs with on the rare occasions that I might see them. However, it's a greater success when the staff discusses my meds with the doc after I leave. Because while a message delivered by a rep gets discounted, a detail delivered by a co-worker slips undetected and unfiltered under the guise of a conversation. And the response is usually better than what I might accomplish.	One's marketing success in a particular office can be strongly correlated to one's success in providing good food for the staff. Goodwill from the staff provides me with critical information, access, and an advocate for me and my drug when I'm not there.
Thought leaders	As a rep, I was always in pursuit of friendly "thought leaders" to groom for the speaking circuit. Once selected, a physician would give lectures around the district. I would carefully watch for tell-tale signs of their allegiance. This includes how they handled questions that criticized our product, how their prescribing habits fluctuated, or simply how eager they were to give their next lecture.	The main target of these gatherings is the speaker, whose appreciation may be reflected in increased prescribing of a company's products. Local speaking gigs are also auditions. Speakers with charisma credentials, and an aura of integrity were elevated to the national circuit and, occasionally, given satellite telecast programs that offered CMEs.	Subtle and tactful spokespersons were the ideal candidates. I politely dismissed doctors who would play cheerleader for any drug . . . at the right price, of course

These descriptions are based on SA's experience working for Eli Lilly and testimony in *IMS Health Inc. v. Ayotte*, US District Court, New Hampshire. Actual tactics may vary.
doi:10.1371/journal.pmed.0040150.t001

Source: Adrian Fugh-Berman and Shahram Ahari (2007), "Following the Script: How Drug Reps Make Friends and Influence Doctors", *PLoS Medicine*, 4(4), pp. 622–623.

Endnotes

¹ *Maheu v. IMS Health Canada*, [2003] F.C.J No. 3 (F.C.T.D.).

² In its website, under *Parliamentary Activities: "Work Product" Information*, the Office of the Privacy Commissioner of Canada notes that British Columbia is the only province that has introduced the notion of "work product" in its *Personal Information Protection Act* (PIPA). It is an exemption that applies to "information prepared or collected by an individual or group of individuals as part of the individual's or group's responsibilities or activities related to the individual's or group's employment or business".

³ *Maheu v. IMS Health Canada*, [2002] F.C.J. No. 750 (F.C.T.D.).

⁴ He fulfilled this requirement, and filed an appeal claiming that the Court was wrong in deeming his purpose as collateral and improper. The appeal was heard on June 17, 2002 and, following a number of motions, the case was eventually settled out-of-court. Court activity for 2001-2004 is outlined in the Federal Court of Canada *Court Index and Docket* listing, at: http://cas-ncr-nter03.cas-satj.gc.ca/IndexingQueries/infp_RE_info_e.php?court_no=T-1967-01 (last accessed on October 15, 2007).

⁵ IMS Health, *Press Releases: IMS Acquires Strategic Decisions Groups Life Sciences Practice*. Last accessed January 19, 2011.

⁶ The Canadian website indicates that such sites include "health care professionals, hospitals, pharmacies and pharmacy chains, software suppliers, wholesalers, pharmaceutical companies and other public sources of information" (IMS Health Canada, *Company Information: Our Partners*).

⁷ IMS Health, *Company Information: IMS Facts at a Glance*. Last accessed January 19, 2011.

⁸ IMS Health, *Press Room: Top-Line Industry Data*. Last accessed January 19, 2011.

⁹ A similar tool is the *Sales Force Effectiveness Precision Suite* which uses raw data to divide customers into segments. With this market simulation tool companies can develop and apply sales strategies that are more accurately tailored to their customers' needs, the nature of their products, and the state of their market.

¹⁰ IMS Health Canada, *Our Services: Commercial Effectiveness – Sales Force Effectiveness*. Last accessed January 19, 2011.

¹¹ IMS Health Canada, *Our Solutions: Forecasting – Market Measurement*. Last accessed January 19, 2011.

¹² IMS Health, *Company Information: IMS Facts at a Glance*. Last accessed January 19, 2011.

¹³ An example is the Pilot Study for Appropriate Anti-infective Community Therapy, an initiative designed to inform health professionals, pharmaceutical representatives and the public on proper antibiotic usage. The study took place between 1995-1997, its design, objectives and findings are discussed in Stewart J. *et al.* (2000), "Pilot study for appropriate anti-infective community therapy: Effect of a guideline-based strategy to optimize use of antibiotics", *Canadian Family Physician*, 46(4): 851–859.

¹⁴ Dr. Roger Korman, former president of IMS Health Canada, highlighted the company's status as "the authority on blowing the whistle on the rampant use of Ritalin in children" and maintained that such information was "put into the public sector by [their] own efforts" in his address to the Standing Senate Committee on Social Affairs, Science and Technology on November 30, 1999.

¹⁵ Temple and Thompson (2007) explore aspects of "market creation" of illnesses such GAD and erectile dysfunction, noting that "once companies have drugs to offer, the 'need' for it, the new language for the 'disease,' and its norms of behavior and response will be established" (p. 76).

¹⁶ IMS Health Canada, *Company Information: Our Partners*, last accessed September 18, 2007.

¹⁷ See also Criton Constantinides' (1991) discussion on the role of ethics codes and the socio-historical circumstances surrounding the status of classical professions.

¹⁸ Some authors cite external causes, such as decreasing government funding, as well as increasing government and private sector intrusions in health care administration (Cruess and Cruess, 2000: 668).

Others like Hoglund *et al.* (2004) point to increased public consultation of health care websites (p. 40). With these resources in hand, patients are more likely to question physician decision-making.

¹⁹ See *Associated Press*, “Lessons from the SARS epidemic”, December 23, 2003, as well as Rob Stein’s article entitled “WHO official denies exaggeration about dangers of swine flu pandemic”, *Washington Post*, January 15, 2010.

²⁰ See Angell (2004) on these ideal market conditions which include elevated drug pricing, long-term patent and intellectual property rights on brand-name products, unfettered rights to direct-to-consumer advertising, and shortened clinical trial periods to ensure early market release times for new products (pp. 105-106).

²¹ This is seen in rarer mainstream pieces on the state of the patient-doctor therapeutic relationship and the credentialing of doctors. See “Doctor and patient, now at odds” by Tara Parker-Pope in the *International Herald Tribune* (July 29, 2008) and *CBC News*, “Canadian doctors should face regular testing: medical school head” (November 4, 2008).

²² See Petronio (1991) and Altman (1975). Information boundary theories emphasize the control of information-flows about oneself through a process of self-regulation – by opening or closing personal boundaries according to the circumstances of the information transaction in question (i.e. type, value or sensitivity of information) (Stanton and Stam, 2003: 154).

²³ See *R. v. Dyment*, [1988] 2 S.C.R. 417 at pp. 431-432.

²⁴ See *R. v. Silveira*, [1995] 2 S.C.R. 297 and *R. v. Tessling*, [2004] 3 S.C.R. 432. *Tessling* illustrates the ways in which an expectation of privacy varies according to the type of space (at par. 22).

²⁵ See *R. v. Mills*, [1999] 3 S.C.R. 668.

²⁶ A large part of privacy’s development in case law revolves around the interpretation of section 8 in different contexts: from the use of “forward looking infra-red technology” to detect marijuana grow-ops (*R. v. Tessling*, [2004] 3 S.C.R. 432), the use of warrantless strip searches (*R. v. Golden*, [2001] 3 S.C.R. 679) and video camera surveillance (*R. v. Wong*, [1990], 3 S.C.R. 36; *R. v. Duarte* [1990] 1 S.C.R. 30), to the collection of bodily samples without authorization (*R. v. Stillman*, [1997] 1 S.C.R. 607, or more recently *R. v. Rodgers*, [2006] 1 S.C.R. 554). Privacy is also protected through the right to security of the person guaranteed under section 7. In *R. v. O’Connor*, [1995] 4 S.C.R. 411, section 7 was “found to include protection from psychological trauma” – wherein the trauma itself could entail a privacy infringement. Privacy was equally discussed within the context of defamation in *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130.

²⁷ British Columbia, Manitoba, Newfoundland and Saskatchewan have created a statutory tort of invasion of privacy (Craig, 1997, *supra* note 2 on p. 357). In Quebec, the tort was codified into the “right to respect for his private life” under section 5 of the province’s *Charter of Human Rights and Freedoms*. It is also defined under article 3 of the *Civil Code of Quebec* as the “right to life, the right to the inviolability and integrity of his person, and the right to the respect of his name, reputation and privacy.” Common law torts such as defamation and trespass provide a marginal level of after-the-fact protection and remedy. Craig (1997), however, notes that a potentially influential tort of privacy invasion “rooted in personal interests such as dignity and autonomy, as opposed to property rights” (p. 369) has recently emerged in Ontario lower court jurisprudence, see *Saccone v. Orr* (1981) 34 O.R. (2d) 317, 19 C.C.L.T. 37 (Co.Ct.), *Roth v. Roth* (1991), 4 O.R. (3d) 740, 9 C.C.L.T. (2d) (C.J. (Gen. Div.)) and *MacKay v. Buelow* (1995), 11 R.F.L. (4th) 403, 24 C.C.L.T. (2d) 184 (Ont. Gen. Div.).

²⁸ The *Privacy Act* (R.S., 1985, c. P-21), defines “personal information” as “information about an identifiable individual that is recorded in any form including, without restricting the generality of the foregoing, (a) information relating to the race, national or ethnic origin, colour, religion, age or marital status of the individual, (b) information relating to the education or the medical, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved, (c) any identifying number, symbol or other particular assigned to the individual, (d) the address, fingerprints or blood type of the individual, (e) the personal opinions or views of the individual except where they are about another individual or about a proposal for a grant, an award or a prize to be made to

another individual by a government institution or a part of a government institution specified in the regulations, (f) correspondence sent to a government institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to such correspondence that would reveal the contents of the original correspondence, (g) the views or opinions of another individual about the individual, (h) the views or opinions of another individual about a proposal for a grant, an award or a prize to be made to the individual by an institution or a part of an institution referred to in paragraph (e), but excluding the name of the other individual where it appears with the views or opinions of the other individual, and (i) the name of the individual where it appears with other personal information relating to the individual or where the disclosure of the name itself would reveal information about the individual...". There is equally a list of exceptions to what is deemed "personal information" in accordance with the *Access to Information Act*, R.S., 1985, c. A-1.

²⁹ See Richard Simpson, "Personal Information Protection and Electronic Documents Act: Process for the Determination of 'Substantially Similar' Provincial Legislation by the Governor in Council", *Canada Gazette*, 136(31), published on 3 August 2002, at: <http://canadagazette.gc.ca/part1/2002/20020803/html/notice-e.html#i10>. Last accessed on November 17, 2007.

³⁰ All other provinces and territories currently have public sector information protection and access legislation and resort to PIPEDA as their private sector legislation.

³¹ Christopher Berzins (2004) discusses these catalyzing factors for critique, noting four fundamental problems with the ways in which the oversight and the enforcement of PIPEDA have been carried out since its enactment: (1) the legislation's "heavy emphasis on complaint resolution"; (2) the Commissioner's office has not consistently utilised provisions built into PIPEDA to "promote proactive and systemic approaches to privacy compliance"; (3) the lack of transparency in Commissioner's "compliance initiatives"; and (4) the overall level of uncertainty surrounding the approaches used to oversee and enforce PIPEDA (pp. 113-114). See also the Jennifer Stoddart's (current Privacy Commissioner of Canada since 2003) response to a few of Berzins' critiques in her publication entitled "Cherry Picking Among Apples and Oranges: Refocusing Current Debate About the Merits of the Ombuds-Model Under PIPEDA", October 21, 2005; as well as Lisa M. Austin (2006), "Reviewing PIPEDA: Control, Privacy and the Limits of Fair Information Practices", *Canadian Business Law Journal*, 44(1): 21-53.

³² Manitoba's *Personal Health Information Act* (PHIA) was proclaimed as law in 1997, the *Health Information Act* (HIA) in Alberta came into effect later in 2001, the *Health Information Protection Act* in Saskatchewan came into force in 2003 – a year before Ontario's recently developed *Personal Health Information Protection Act* (PHIPA). Provinces like New Brunswick are in the early stages of legislative drafting: the New Brunswick Minister of Health announced, on May 23 2007, the establishment of a *Personal Health Information Task Force* with the aim of developing legislation regarding "the collection, use and disclosure of PHI [personal health information] in the province" (New Brunswick Health, 2007: 2).

³³ See Katharina Pistor and Chenggang Xu's Chapter "The Challenge of Incomplete Law and How Different Legal Systems Respond" in A. Breton and M. Trebilcock (eds.) (2006) *Bijuralism: An Economic Approach*, pp. 71-108. The theory does not highlight the incompleteness of law as a negative reality but as fact that law, even in its most "complete" form by the lawmaker's own design, "cannot effectively deter harmful actions at a level that would be socially optimal" (p. 72) – especially in a field of law challenged by rapid socioeconomic development and technological change.

³⁴ For a preliminary exploration of these accounts, see *Selling Sickness* by Ray Moynihan and Alan Cassels (2006), and Gary Greenberg's (2007) satirical article "Manufacturing depression: A journey into the economy of melancholy".

³⁵ Paul Schwartz (2000) provides an applied discussion on internet privacy – which discusses the ways in which "new structures of power over individuals is emerging" due to the lack of effective measures to control personal information flows over the internet (p. 815).

³⁶ See also John Harrington (1996), pp. 349-350.

³⁷ The lecture is entitled "What is an author?" and reproduced in Rabinow and Rose (1994) at pp. 377-391.

³⁸ Kevin Haggerty and Richard Ericson (2000) use a similar term – “surveillant assemblage” – to describe the process of “abstracting human bodies from their territorial settings, and separating them into a series of discreet flows” (p. 605).

³⁹ Identification entails the tagging of an individual, wherein a personalized name and identity is attached to the body of information on him or her. Classification then controls for the diversity of possible consumer behaviours by grouping individuals into “workable categories” based on shared characteristics (Arvidsson, 2004: 459–460).

⁴⁰ Haggerty and Ericson (2000) discuss this aspect of *acceptance*, which is described as tendency wherein individuals “monitor their behaviour in light of the thresholds established by such surveillance systems” – and are therefore “often involved in efforts to maintain or augment various social perks such as preferential credit ratings, computer services, or rapid movement through customs” (p. 615).

⁴¹ The words and expressions searched included: “data-mining”, “prescription data-mining”, “pharmacy data-mining”, “prescription profiles”, “physician privacy”, “physician privacy intrusion” and “data-mining privacy”.

⁴² These include WilsonWeb, IngentaConnect, PubMed and Public Library of Science (PLOS).

⁴³ This particular consideration does not presume that the audience takes up the intended message of each surveyed article.

⁴⁴ An example is Dr. Dick Zoutman’s interview for the CBC’s *Disclosure* (2002) piece on data-mining. In the interview, he describes the roots of his own awareness of the practice: “It came to light by the way that we were being detailed by the pharmaceutical companies, that they knew more about my prescribing practice than I did....it was them asking me questions that they already knew the answers to.”

⁴⁵ See Jacky Law’s (2006) account of the gradual disappearance of the “public scientist” due to the commercialization of medical research (p. 21).

⁴⁶ *Associated Press*, “Med schools warn about drug sales pitches”, November 3, 2006.

⁴⁷ See Law (2006), Moynihan and Cassels (2005), Angell (2004) and Reidy (2005).

⁴⁸ Dr. Brad Drexler is also quoted as explaining how physician-linked data plays an important role in changing “the equation between doctor and drug rep” (Whitney, 2006).

⁴⁹ In discussing the rhetorical significance of the Oath and its professional symbolism, Kerkatch (2005) refers to a study by Lisa Keränen, who “links the practice of ritual recitation of the Oath to medicine’s professionalization movement in the 1850s, and argues that recitation of the Oath in a communal setting binds practitioners to one another, situates them in a tradition, and reiterates a set of values to unite them as a profession” (p. 140).

⁵⁰ See Angell’s (2004) depiction of the industry as “a vast marketing machine” (as opposed to an “engine of innovation”) (p. 20). Moynihan and Cassels (2005) similarly refer to the “industry’s promotional machinery” in their preface (p. xvii).

⁵¹ See “Doctors’ continuing education depends too much on drug companies: journal” released by *The Canadian Press*, 25 March 2008. The article cites the findings published by the Canadian Medical Association, which urge an overhaul of the funding system underlying continuing medical education initiatives. See also Guadagnino (2006) for more complex explanation of these industry-profession tensions.

⁵² Recommendations include the establishment of independent provincial boards that oversee prescription data mining, or a royalty system which pays doctors and pharmacists for mining the data.

⁵³ IMS Health, *Company Information – Our History*, last accessed on January 28, 2011.

⁵⁴ IMS Health Canada, *Company Information – Commitment to Privacy*, last accessed on February 23, 2011.

⁵⁵ *Ibid.*, supra note 50.

⁵⁶ Companies adapt to observed tendencies. For instance, female doctors request more free drug samples

for their patients, as well as “shorter CME [Continuing Medical Education] events and less schmoozing” – which can indicate a lower tolerance for drug representatives (Clarke, 2003).

⁵⁷ IMS Health Canada, *Company Information – Commitment to Privacy*, last accessed on February 23, 2011.

⁵⁸ This discussion is reproduced in Rabinow and Rose (1994) at pp. 400-401.

⁵⁹ *Ibid.*, pp. 195-211.

⁶⁰ The interview is entitled *The Ethics of the Concern of the Self as a Practice of Freedom*, conducted by H. Becker, R. Fornet-Betancourt and A. Gomez-Müller on January 20, 1984, reproduced in Rabinow and Rose (1994) at p. 34.

⁶¹ M. Foucault, “*Omnes et singulatim*: Toward a Critique of Political Reason”, the text of a series of lectures delivered at Stanford University in 1979, reproduced in Rabinow and Rose (1994) at pp. 180-201.

⁶² M. Foucault, “Society must be defended” in Rabinow and Rose (1994) at p. 294.

⁶³ The Pfizer training staff, according to Reidy (2005), regularly portrayed representatives from competitor companies in a negative manner so as to convince trainees that they were superior in the quality of their work. Speaking of his counterparts: “They lied. They cheated. Their women dressed slutty. They bought physicians’ love with extravagant dinners and golf at Pebble Beach, instead of earning it through ethical practices. (I later learned that *every* company told its reps that they did things the ‘right way,’ while the other companies cheated.)” (p. 24).

⁶⁴ An example is the DM’s assessment of his representatives’ work ethic through routine checks in his voicemail system. According to Reidy (2005), the DM leaves his representatives an early morning voicemail message at 6am every day. He then checks his voicemail system to determine when each of his representatives listened to the message. The recorded times give him an idea of whether they are sleeping in, or genuinely starting their visits early. He can also trace the phonecall made by each representative to determine whether or not he or she is on the road, en route to a visit, or at home (pp. 88-90).

⁶⁵ See Windschuttle’s discussion in Nola (ed.), 1998, at p. 15.

⁶⁶ *Multinational Monitor*, “The First Amendment Gone Wild: Big Pharma’s ‘Right’ to Find Out What Doctors are Prescribing”, in the *Multinational Monitor*, January 10, 2008.

⁶⁷ *Associated Press*, “Medical schools warn about drug sales pitches”, November 3, 2006.

⁶⁸ The ability to monitor and assess doctors is being acquired by other parties in health care. Dyson (2008) reports that patients are increasingly resorting to websites that evaluate and rank physicians and hospitals such as HealthGrades.com (p. 54). The need to know the caregiver on a more thorough level is increasingly becoming part of the patient psyche within the therapeutic relationship.

⁶⁹ See M. Foucault (2007), “What is Critique” in *The Politics of Truth*, at p. 60.

⁷⁰ An article by Fabian Kessl and Hans-Uwe Otto on pedagogic professions elaborates on this shift in stature. The authors note that: “[w]ith the multiplication of information, the exclusivity of the professions’ knowledge and the accompanying dynamics that cumulate in the image of scientific expertise and simultaneous scientific counter-expertise become brittle” (p. 258).

⁷¹ The author is thankful to Dr. Douglas B. Ford for providing the source: Office of the Information and Privacy Commissioner, “Alberta Pharmacists and Pharmacies” Order H2002-003 (File Number H0036), 19 March 2003.

⁷² These data items include the prescribing doctor’s first and last names, identification number, postal code, as well as items such as the patient’s medical condition (or reason for use), drug name and quantity, refill and repeat authorizations, payment type, etc.

⁷³ Other states that are considering similar legislation are Missouri, Nebraska, Arizona, Illinois, Kansas, Rhode Island, West Virginia and Texas (Mullin, 2007). Data restriction legislation has been introduced in the states of Hawaii, Maryland, Massachusetts, Nevada, New York, Washington and the District of Columbia have introduced legislation (Prescription Project, *Fact Sheet: Prescription Data Mining*, 2008).

⁷⁴ See “IMS Challenges State Laws Restricting Access to Critical Healthcare Information”, on the IMS Health website, at: www.imshealth.com/portal/site/imshealth/menuitem.a953aef4d73d1ecd88f611019418c22a/?vgnextoid=f1b5d3634a088110VgnVCM10000071812ca2RCRD&vgnnextfnt=default.

⁷⁵ *Multinational Monitor*, “The First Amendment Gone Wild: Big Pharma’s ‘Right’ to Find Out What Doctors Are Prescribing”, January 10, 2008.

⁷⁶ IMS Health, “IMS Challenges State Laws Restricting Access to Critical Healthcare Information”.

⁷⁷ Office of the Attorney General for the State of Vermont, “Supreme Court Grants Vermont Request to Review Data Mining Case” (press release), January 7, 2011.

⁷⁸ Such a recognition, Dr. Chan argued, can be further achieved by referencing the Association’s PIPEDA awareness-raising tools (“PARTs”) – a set of guidelines for health care providers that were developed in collaboration with the federal government.

⁷⁹ According to a brochure published by the Nurse Practitioners’ Association of Ontario, this profession can “diagnose and treat illness and/or injuries”; “perform physical check-ups”, “order and interpret diagnostic tests”, “write prescriptions”, “provide counselling and education”, “provide supportive care through illness”, “provide treatments and/or procedures” and “make referrals to family physicians, specialists and other health professionals” (p. 2).

⁸⁰ CBC Radio interview with Dr. Brian Goldman, January 8, 2009, available on the *Sudbury District Nurse Practitioner Clinics* website, *In the News*, at: http://sdnpc.ca/index.php?option=com_content&task=blogcategory&id=9&Itemid=11.

⁸¹ Under its privacy policies, the Canadian Medical Association’s website clarifies that it does “not sell or trade the personal information collected at cma.ca” though it may share personal information about members with third party product and service providers, with CMA subsidiary companies, or with other parties “under authority of a valid legal requirement such as a law, regulation or search warrant”. The policies clarify, however, that in all other cases, permission from members will be sought prior to any personal information disclosure (“Privacy Policies for the CMA and its subsidiaries – Disclosing Information”, CMA.ca, last accessed February 28, 2011).

⁸² See “About Us” on the *No Free Lunch* website, last accessed July 3, 2008.

⁸³ See “About Us” on the website of *The Prescription Project*, last accessed July 3, 2008.

⁸⁴ An example is a letter from GlaxoSmithKline Inc. posted on Health Canada’s website, the company advises health care professionals *not* to prescribe the anti-depressant Paxil (paroxetine hydrochloride) to children or teenagers under 18 years old “due to a possible increased risk of suicide-related adverse events in this patient population” (Phillips, 2003: 1).

⁸⁵ *Ipsos Insight*, “Long Road Ahead for DTC Advertising”, October 26, 2004.

⁸⁶ *Pharmaceutical Business Review*, “UKs R&D in decline, survey finds”, May 6, 2008.

⁸⁷ See the press release on the PricewaterhouseCoopers website entitled “Asia-Pacific to replace United States and Europe as pharmaceutical industry powerhouse”, August 7, 2007.

⁸⁸ *IMS Health*, “New Hampshire” [press release], last accessed February 28, 2011.

⁸⁹ The author would like to thank Dr. Douglas B. Ford for forwarding the article by Morris *et al.* (2004) as an indication of the “future” of drug marketing approaches.

⁹⁰ Vioxx was withdrawn from the market by Merck in September 2004, upon the release of a U.S. study which found that the drug “doubled the risk of heart attack or stroke if taken for 18 months or longer” (see “Pathologist Backs Merck in Vioxx Trial”, *New York Times*, August 9, 2005).

⁹¹ Bayer Pharmaceutical withdrew the product from the market in 2001 when it was found that 31 deaths within the U.S. were due to fatal rhabdomyolysis – or muscle breakdown – a side effect of the drug (Sternberg, 2001).

⁹² For a discussion on the use of patient health records for online marketing targeted at physicians, see Steve Lohr, “Google and Microsoft Look to Change Health Care”, *New York Times*, August 14, 2007; Molly Merrill, “Data mining incident puts spotlight on operating in a ‘new frontier’”, *Healthcare IT News*, October 12, 2010. Sara Michael provides an interesting discussion on the use of social networking sites in health care contexts, “Privacy in a Social Media World”, *Physicians Practice*, July 14, 2010.

⁹³ This comfort level is illustrated in physicians’ routine dependence on product information released by pharmaceutical companies, as well as the general lack of impartial information about drugs. An example of this appeared in a CBC News article published in 2007 that drew a linkage between the widespread practice of prescribing atypical antipsychotics to seniors suffering from dementia – despite Health Canada’s issued warning of increased risk of death in people over the age of 65 – and the daily circumstances of physicians. The prescribing habits have their roots in the “noise” of multiple product advisories released by pharmaceutical companies, drowning out important warnings issued by public agencies and departments. Doctors come to rely on information generated by drug companies. Dr. John Haggie, board member of an *ad hoc* working group on pharmaceutical issues under the Canadian Medical Association, states that the CMA is attempting to correct these circumstances by working “with the academic community to provide doctors with unbiased education material to replace documents received from drug companies” and develop quick update tools to publicize warnings in an efficient manner. See “Doctors rely too heavily on drug company data: CMA”, *CBC News*, December 19, 2007.

⁹⁴ See Mary Carmichael’s article in the *Boston Magazine*, “Bitter Pills”, October 23, 2009, *Boston Magazine*, which discusses the scrutiny faced by the faculty at Harvard Medical School for its ties to major pharmaceutical companies.

⁹⁵ For a comprehensive discussion of the direct-to-consumer issue see the article by Victor E. Schwartz, Michael J. Hulka, Cary Silverman and Christopher E. Appel (2009), “Marketing Pharmaceutical Products in the Twenty-First Century: An Analysis of the Continued Viability of Traditional Principles of Law in the Age of Direct-to-Consumer Advertising”, *Harvard Journal of Law & Public Policy*, 32(1): 333–338.

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