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COVID-19 & Disaster Capitalism – Part I

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Abstract

In this three-part series we examine the extent to which disaster capitalism and the medical-industrial complex turned the pandemic into a 'golden' opportunity to enhance corporate profits which took place, in large part, at the taxpayer's expense through appropriation of public resources. In the first part we examine the rise of this predatory social ideology and the strategies its adherents have employed to assure its success. In the second part we examine the social and economic consequences of disaster capitalism during the COVID-19 pandemic which, in the end, led to the preventable loss of hundreds of thousands of American lives. In the final article we point to the necessity of broad reform not only of the healthcare system but of American democracy and raise challenging questions as to how this should be accomplished and, importantly, whether the American public is up to the task.

Key Words: Disaster Capitalism, Corporatism, COVID-19, Shock Doctrine, Dominator Hierarchies

Beyond impacting countless lives across the globe, the COVID-19 pandemic unmasked critical flaws in the US healthcare system regarding issues such as access to effective treatment, quality of care, inequities in distribution of care, supply shortages, spiraling costs, and broad failure of public health policies. All these factors coupled with lack of preparedness and the economic downturn during the pandemic hampered the ability of the system to respond effectively leading to devastating consequences for the US public. A simple comparison of outcomes in other countries illustrates this point.

With about 4% of the global population the US has accounted for 15.8% of the overall COVID-19 mortality despite having the highest global healthcare expenditures which, in 2020, amounted to $11,945 per capita [1,2]. By contrast, India, with 17.7% of the world's population — over four times that of the US — has had about half the number of deaths despite annual healthcare expenditures of only about $64 per capita [3]. A comparison between the US and Canada, with similar demographic and socioeconomic patterns, further highlights the disparities: Canada, with about 11.4% of the US population, has had only about 4% of COVID-19 deaths despite healthcare expenditures less than half of the US or about $5,736 per capita. Such incongruities point an incriminating finger at the US healthcare model.

From its origins in the late 19th century the US healthcare system was based on the reigning industrial model and much of the seed capital and early philanthropic support came from wealthy industrialists [4]. Not coincidentally,

we observe a parallel rise in the pharmaceutical industry throughout Europe and the US. From the onset the healthcare system was destined to become a sovereign industry despite numerous concerns that swirled around the nascent social project: Who would control it? How would it be financed? Would government or private insurance companies fund healthcare services? How would hospitals be incorporated into this novel social experiment? What influence would the medical profession wield in its affairs?

Over the decades what evolved was a vast medical-industrial complex, a health empire driven by power, politics and profit in which hospitals became autonomous centers of power with physicians and nurses as points of service. Alongside this rose a contorted pay-as-you-go system of financing under the control of large for-profit insurance companies. Eventually, due to lack of accessibility by large segments of the population into this market-based network, a side-by-side government-funded payment system, Medicare and Medicaid, was established for the elderly and low-income groups. Despite such supplemental assistance up to 30 million Americans remain uninsured and about 87 million underinsured.

Over the past four decades there has been a dramatic uptick in the extent of privatization in the healthcare industry not only among hospitals but with services such as hospice, psychiatric care, outpatient surgery, dialysis centers and clinical laboratories [5]. Privatization, in turn, has led to higher costs, more bureaucracy, redundancy of services, lower consumer satisfaction, and widespread profiteering compared with not-for-profit publicly funded programs. Even Medicare is now administered by for-profit entities [6]. And yet during the pandemic such for-profit entities had few qualms about accepting governmental subsidies and public funding to keep their doors open.

The 20th century rise of the medical-industrial complex and its unfettered embrace of corporatism, its increasingly deep connections with high finance and the backrooms of Wall Street, primary loyalty to its financial stakeholders, its unapologetic emphasis on wealth creation, and the relentless dismantling and privatization of what had been self-sustaining public programs, has led to an unprecedented ethical crisis in American healthcare. Exacerbated by the COVID-19 crisis, the medical-industrial complex now undermines the principles upon which the healthcare system was ostensibly established.

In March, 2020, Congress passed the $2.2 trillion Coronavirus Aid, Relief, and Economic Security (CARES) Act to provide economic assistance for American workers, small businesses, and families to counter disruptions caused by the pandemic [7]. As part of this package Congress established the Provider Relief Fund which earmarked $178 billion for hospitals and healthcare providers 'to compensate for financial losses and unanticipated costs during the pandemic'. Included in this package was $14.8 billion in support of COVID-19 vaccine development. Medicare payments to hospitals for COVID-19 admissions were increased by 20% during the pandemic along with payment for administration of the vaccines. But in many cases the assistance package was not used as intended [8].

Due to governmental failures in maintaining national stockpiles of critical supplies such as masks, gowns, gloves, and ventilators, supply shortages in hospitals began to crop up by early April, 2020. Private contractors were solicited by the federal government without adequate vetting or bidding resulting in rampant fraud, price-gouging, and profiteering [9-13]. COVID-19 test manufacturers like Abbott Laboratories received billions of federal dollars despite the widely recognized flaws of polymerase chain reaction (PCR) tests or that such testing had virtually no impact on viral transmission or COVID-19 outcomes [14-17]. Pfizer and Moderna raked in over $50 billion during 2021 largely on vaccine revenues even though research and development was publicly funded [18, 19]. In each of these instances the net result was massive transfer of public assets into private coffers with arguable benefits. A similar phenomenon occurred in hospital systems.

Throughout 2020 after lockdowns were initiated there was a drastic decline in outpatient activity across the entire healthcare system and economists projected this would result in billions in lost revenue for hospitals and physicians. The Provider Relief Fund was intended to mitigate financial hemorrhaging but proved superfluous for some. Despite accepting hefty bailout packages large systems like Cleveland Clinic, Mayo Clinic, Kaiser Permanente, Tenet Healthcare and for-profit entities like HCA, those that cater to the privileged, reported billions in net income [20-22]. By the same token health insurance companies reaped sky-high profits [23-24]. But the grass wasn't so green on the other side of the tracks.

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Medium-sized and small hospitals struggled as the pandemic widened the gap between the haves and have-nots. Urban and rural hospitals serving the poor were particularly hard hit and sustained a record number of bankruptcies and closures [25-27]. Cushioned by federal bailout money multiple large health systems went on spending sprees to buy out weakened competitors while hospitals serving the poor barely kept their doors open [28, 29]. It was survival of the fittest: in the end hospitals at the top of the food chain with the fattest checkbooks came out winners.

For caregivers inside the system the picture wasn't so rosy either. Faced with chronic supply shortages, inundated by an endless stream of gravely ill COVID-19 patients, and working long, stressful hours, many threw in the towel: during the pandemic about 18% of the workforce quit their jobs [30-32]. Commonly cited reasons included burnout, emotional trauma, and moral distress. And as healthcare systems faced mounting nurse shortages, for-profit contracting agencies rushed in to fill the gap. Predictably, they too reaped large profits leading to accusations by hospitals they were exploiting the pandemic [33]. Meanwhile hospitals and private corporations continued to buy out physicians' practices and now employ about 70% of US physicians [34]. The food chain is more than metaphor: such endocannibalism produces a dynamic in which the healthcare system literally eats its own.

The tragic irony of the COVID-19 pandemic and the American-inspired doctrine of disaster capitalism is writ large at the social level: as tens of millions of US citizens struggled with the economic fallout—record levels of unemployment, small business closures, inability to make mortgage payments or provide adequate food for their families, surging levels of mental illness and drug abuse, and breakdowns in local social networks—five hundred new American billionaires rose out of the ashes [35].

The rise of corporatism and the for-profit movement in healthcare over the 20th century has bred disaster after disaster of which the COVID-19 pandemic is only the most recent example. Proponents of the market-based healthcare system claim that competition and free markets produce better care and more choices for the public. The COVID-19 pandemic lays these myths to rest. In reality, despite having the most expensive healthcare system in the world, the US ranks near the bottom on a wide range public health measures among developed nations [36].

In this three-part series we examine the extent to which disaster capitalism and the medical-industrial complex turned the pandemic into a 'golden' opportunity to enhance corporate profits which took place, in large part, at the taxpayer's expense through corporate appropriation of public resources. In the first part we examine the rise of this predatory social ideology and the strategies its adherents have employed to assure its success. In the second part we examine the social and economic consequences of disaster capitalism during the COVID-19 pandemic which, in the end, led to the preventable loss of hundreds of thousands of American lives. In the final article we point to the necessity of broad reform not only of the healthcare system but of American democracy and raise challenging questions as to how this should be accomplished and, significantly, whether the American public is up to the task.

Disaster Capitalism and the Shock Doctrine

The Great Depression of the 1930s, a defining moment in the evolution of 20th century economic theories, serves as an apt entry into our examination of market economies and disaster capitalism. The depression was a global event defined by drastic decreases in industrial production, recurring banking panics, incapacitating deflation, massive unemployment and poverty. Like the dot-com bubble of the late 1990s or the mortgage crisis of 2007, the Great Depression was entirely a product of market forces and the market's inability to self-regulate and self-correct. The depression led to widespread calls for an end to 'laissez-faire' economics and more hands-on governmental oversight and regulation.

During the 1930s English economist John Maynard Keynes spurred a revolution in macroeconomic thought by debunking Adam Smith's 18th-century legacy of self-regulating markets. Keynes stumped for governmental imposition of fiscal and monetary policies to prevent or counteract the economic consequences of recessions and depressions. By the late 1930s most western nations had begun to implement his ideas and Keynesian economics had gained a decisive foothold in capitalist economies. But such emergent economic principles had a muzzling effect on corporate profits.

Keynes' influence was fiercely opposed in the US by factions aligned with University of Chicago economist Milton Friedman who argued in favor of unregulated markets. Friedman, like Adam Smith two centuries

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earlier, regarded markets as self-regulating systems in which individuals, acting in their own interests, create maximum benefit for all. Market phenomena like supply, demand, pricing and employment, similar to mass, force and acceleration in Newton's equations, were said to possess fixed relations to each other: a robust economy occurs when they are in equilibrium; high unemployment, inflation, or recessions indicate market disequilibrium which, according to Friedman, is a by-product of external distortions. Governmental regulations, Friedman claimed, only impose further constraints on the market; instead, all constraints must be stripped away.

The Chicago School economists, impassioned evangelists for governmental and economic reform to counter the loathed Keynesian system, advanced a threefold prescriptive strategy for liberation of markets: erasure of all governmental regulations that hinder corporate profitability; selling off publicly held assets to private corporations for establishment of new revenue streams; governmental down-sizing with curtailment of social welfare programs and other public projects. Friedman's neo-capitalist economic vision resonated strongly within the corporate sector and among proponents of a colonialist US superpower.

The rise of Friedman's fundamentalist economy over the past-half century has radically altered the face of American and global culture: megalithic trans-national corporations, privatization of once-public works and concerns, brand identity, iconic logos, never-ending market campaigns, and rampant consumerism now blur the boundaries between governance, commerce, democracy and totalitarianism. Political labels like liberal, conservative, progressive, or traditional no longer accurately depict the emerging social landscape which demands a whole new nomenclature under the broad rubric of corporatism.

Friedman understood that old habits die hard. Implementation of his neo-capitalist theory required special priming conditions: 'Only a crisis—actual or real—produces real changes'. Once that crisis occurs, he wrote, alternatives to existing policies must be implemented in order to overcome 'the tyranny of the status quo'. When the crisis strikes, those in power must act swiftly to impose rapid and irreversible change before society slips back into its old habits. As Machiavelli noted, trauma should be inflicted all at once. Friedman introduced his economic shock therapy abroad in the 1973 Chilean coup d'état in which Augusto Pinochet seized power from democratically elected president Salvador Allende.

In her riveting exposé *The Shock Doctrine* (2007) journalist Naomi Klein chronicles the global rise of disaster capitalism and its disastrous political, economic, social and humanitarian consequences [37]. Across the globe Friedman's Chicago School coups have been capitalizing on crises, conquering nations and winning wealthy corporate and oligarchic converts since the 1970s: Chile, Argentina, Russia, China, Poland, and South Africa to name a few. In the US disaster capitalism has played a pivotal role in domestic tragedies such as 9/11, Hurricane Katrina, the subprime mortgage crisis of 2007, and, now, the COVID-19 pandemic.

Friedman and his Chicago School disciples regarded natural or manufactured crises such as hurricanes, floods, market meltdowns, wars or terrorist attacks as the ideal milieu in which to inflict cultural shock therapy in order to implement change. Such shocks disorganize, disorient, confuse, kindle fear and uncertainty leaving the population vulnerable to manipulation. The goal is to wipe the slate clean and push the reset button. Klein describes a one-two punch strategy: primary shocks disrupt social patterns and habits, the public's ability to make sense of events, and to react decisively; periods of collective trauma are then exploited to allow those in power to take control of governmental policy-making and implement far-sweeping changes.

While disaster capitalism can operate under democratic conditions optimal effects are obtained in authoritarian settings during which democratic practices are temporarily or permanently suspended. Crises, natural or manufactured, disrupt politics-as-usual constituting what Klein calls 'democracy-free zones' wherein usual rules do not apply and leaders can make decisions autonomously. During the pandemic the appointment of Anthony Fauci as the COVID-19 'czar,' imposition of lockdowns, and FDA policies such as Emergency Use Authorization allowed for cessation of normal consensus driven proceedings.

Other practices that fit hand-in-glove with corporatist takeover strategies include disruption of communal dynamics: suspension of mass gatherings and rallies, including cultural and religious events, thereby limiting

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the public's ability to develop social networks and devise grassroots solutions. The flip side of this strategy, isolation of the individual, induces fear and anxiety, i.e., psychological regression. The intent of shock therapy, says Klein, is to physically and psychologically uproot the population to create 'malleable moments' in which to effect desired change. Whether by intention or not, the lockdowns, quarantines, and incessant fear-mongering during the pandemic played effectively into this dynamic.

Central to all corporatist power seizures is information control which is the point at which the line between democratic and totalitarian systems becomes blurred if not erased. Narratives which serve corporatist stakeholders take the form of disinformation or propaganda. In all Chicago School sponsored coups imposition of a free market – meaning one in which corporatism could flourish – became conflated with propaganda about elimination of a shared enemy – meaning socialist or communist influences in the culture, whether real or only imagined. During the SARS-CoV-2 pandemic any discourse that deviated from the corporatist stakeholders' self-serving narratives in similar fashion became the commonly shared threat which had to be eliminated by the medical-industrial complex.

Once established the authoritarian narrative is fiercely defended against any opposition: alternative perspectives are suppressed and critics silenced, often violently. During Pinochet's bloody coup thousands of dissenting Chileans, known as the *Desaparecidos,* were forcibly 'disappeared' and never seen again. Such occurrences have been reported in every corporatist putsch across the globe. Dissent is not part of the game plan: authoritarian regimes are the necessary means to unchecked corporate economic freedoms. During the pandemic critics of enforced social policies such as lockdowns and proponents of early COVID-19 treatment regimens challenged the narrative. Those accused of spreading such 'misinformation' were silenced, professionally discredited, and expunged from social media platforms such as Twitter, Facebook and others.

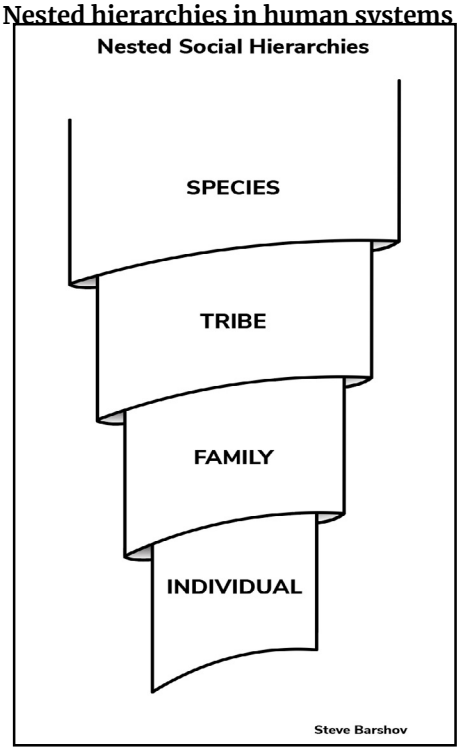
Chaos and fear go hand-in-hand with corporatist assaults on the public domain. Disaster capitalism lurks in the shadows wherever massive wealth accumulation occurs alongside real or manufactured crises. In every locale Chicago School policies have triumphed over the past five decades the end result is plutarchy, an incestuous alliance between large corporations and wealthy politicians. Once corporatism prevails it is invariably accompanied by further concentration of wealth and power into the hands of a few with amplification of social inequalities. The events described during the COVID-19 pandemic were not unintended consequences of well-meaning, benevolent acts but of unchecked predation and opportunism by the medical-industrial complex.

The Hierarchy Problem

In order to sort through these issues, we need to develop an appropriate framework which necessitates introducing the concept of hierarchy. In a general sense, hierarchy refers to ubiquitous patterns of organization in which phenomena are ranked from higher to lower in order of perceived import. The term, from Greek denoting 'the rule of the high priest,' implies the exercise of power which tends to polarize matters. Hierarchy is roundly perceived as bad. We thus need to examine its broader and more encompassing nuances.

From a purely functional perspective hierarchy seems less an exercise in power and more descriptive of how natural systems across a wide spectrum tend to aggregate and self-organize. Take human systems (Figure 1) which form the intersection between the biological and social domains: biological individuals exist within families, families within social groups or tribes, and tribes, ultimately, belong to the denomination we call species.

Figure 1. Nested hierarchies in human systems



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This four-tier arrangement highlights defining aspects of all hierarchies: each level represents a self-sustaining whole with its own governing dynamics; with each step, up the 'ladder' we move from specific to more general causal layers, from the simple to the complex which possesses immensely more integrative capacity and creative potential. Each individual represents a specific instance of humanity with his or her unique attributes; the species, on the other hand, represents the totality of all human attributes and potential. And yet not a single individual hierarchical level can exist independently and, instead, form vertically nested layers of interacting components, systems within systems within systems. Remove any single level and the whole hierarchy collapses. The same patterns are seen in other natural realms.

Fundamental particles combine to form nuclei, the nucleus constitutes part of the atom and atoms form the substance of molecules. With each step upward the complexity and range of possibility increases until, at last, we obtain the 118 elements of the periodic table, each with widely divergent physical properties and characteristics. Fundamental particles indissociably nest in nuclei which are inextricably bound into atoms which are inseparable from the molecular layer: take away any layer and there is no oxygen, carbon or gold.

Language is no different. We observe a progression from letters, to words, to sentences and, finally, to paragraphs which contain higher levels of complexity, nuance and meaning than their component parts. And yet causality moves in both directions: without letters there are no words, sentences or paragraphs and thus no ability to communicate higher levels of meaning, no great works of literature or poetry. Hierarchy is a fundamental means by which nature organizes and reveals itself. Exercise of power is only inferential.

The ancients were acquainted with hierarchy though not by that name. Instead, they employed the concept of the One and the Many to designate such nested layers of function. Aristotle's Great Chain of Being, Nature's unbroken continuum, with its more-than-implied vertical order, the scala naturae, is laden with hierarchical overtones. Likewise, his four causes—material, efficient, formal and final—represent distinct causal layers nested within one another, proceeding from elemental, inorganic substance, through moving fluidic forces, formative layers that impart shape and function and, finally, the highest and most perfect expressions of being, the continuum, which Plotinus later called the One, a state of indissoluble unity. Each layer possesses increased complexity, refinement and determinative potential. Whatever structure hierarchies might actually possess, they are primarily functional webs of causation that, far from iron-fisted rule, induce vertical evolution and transformation across their domains of influence.

In her widely acclaimed synthesis, *The Chalice and the Blade* (1987), cultural historian and feminist writer Riane Eisler invokes hierarchy to explain human evolution and provide insight into the modern predicament [38]. Weaving together evidence from archeology, art, religion, and history, and viewing phenomena through what she calls a 'gender-holistic perspective,' Eisler develops a fresh, new take on cultural evolution. Underlying the broad diversity of cultures two basic patterns of social organization emerge: the first which she calls the dominator model, also called patriarchy or matriarchy, in which half the society is ranked over the other; and the second, the partnership model, which is based on collaborative linking rather than ranking. We call this second organizational pattern a potentiation hierarchy.

In partnership or potentiation hierarchies, whether in the biological or social domains, diversity is not equated with superiority or inferiority but rather as expressions of the natural order. Eisler invokes the chalice to symbolize the life-generating and nurturing properties of such hierarchies. Whether in living bodies as seen in the morphologic transformation of single cells into tissues and organs, potentiating hierarchies enhance and maximize development of the constituent layers. In the communal realm as evidenced by the historical record, partnership societies tend to be peaceful, egalitarian, and less prone to authoritarian top-down dynamics.

Dominator hierarchies, on the other hand, symbolized by the blade, represent social ranking systems based on the perceived superiority of particular ideologies or beliefs and which are imposed by force or threat of force. In such systems the two-way nexus of influence is replaced by varying degrees of top-down imposition of power ranging from intimidation and coercion to the use of brute force. Extreme cases represent reversions to pure top-down exercises of power as seen in archetypal warrior or totalitarian societies. In dominator hierarchies

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one level assumes pathologic agency at the expense of the entire system and thereby inhibits the creative potential and transformational capacity of the whole.

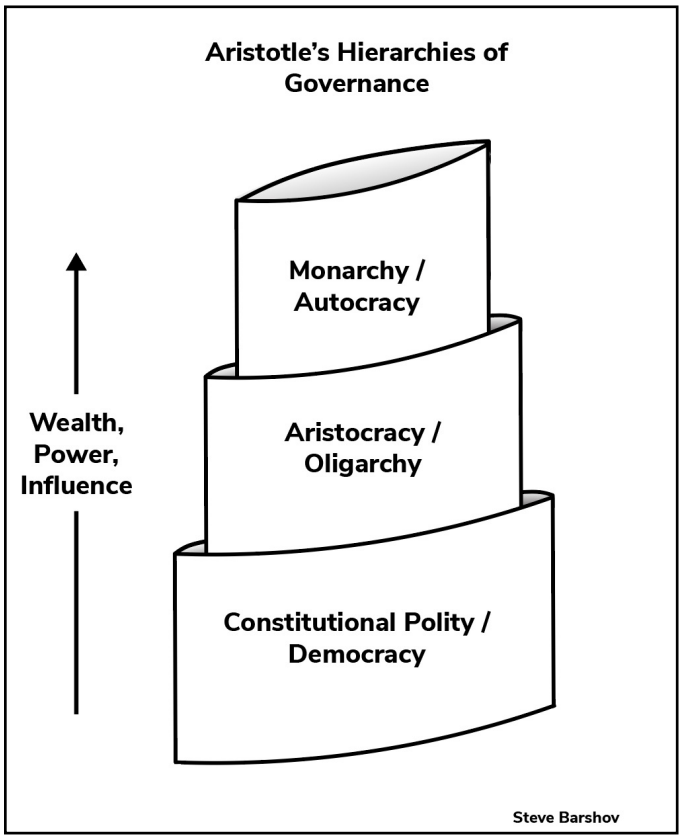
Human evolution, writes Eisler, has been neither linear nor uniform but, instead, punctuated by stops and starts, times of collective advancement interposed by regressive periods, what she calls 'dominator detours,' during which such propensities become implemented by displays of force and power. Naomi Klein's work documents such regressive tendencies over the past half-century in the rise of disaster capitalism. Science, with its dogmatic insistence on the authoritative nature and universality of its knowledge and edicts, has been a strong dominator force in the intellectual realm in recent centuries. During the COVID-19 pandemic the scientific worldview and corporate paradigm in tandem unleashed a witches' brew of dominator pathology.

In Book VIII of *Nicomachean Ethics* Aristotle discusses different governance systems in the ancient world [39]. Good governments are those that act in the best interest of the whole; bad governments act in the interests of a single person or class of people. Monarchy, ideally, represents the rule of the wisest individual, aristocracy the wisest class of individuals, and polity, the rule of the many in which constitutional governance prevails. Bad forms of governance include autocracy, i.e., monarchy corrupted by the interests of the ruler; oligarchy, i.e., aristocracy corrupted by the interests of a powerful few; and democracy, i.e., polity corrupted by the interests of the poor majority, which is to say mob rule.

Given Aristotle's definition of the good life as a harmonious balance between two extremes, it is not surprising that he emphasizes the importance of a strong middle class in societies so as to preserve public support and political stability. The middle class, as the poorest of the rich and the richest of the poor, represents a balance between the opposing interests of the rich and poor within the social domain. Without a strong middle class an equitable and sustainable political milieu is tenuous since governance would be out of balance and vulnerable to the corrupting influences of the extremes.

Once dominator pathologies emerge within the social sphere, either in the form of autocracy or oligarchy, those in power manipulate dynamics in order to reap disproportionate benefit and, as a consequence, power and wealth concentrate in the hands of a few (Figure 2). Totalitarianism, the tyranny of a single absolutist dogma to the exclusion of all others, is the logical endpoint in cultures based on the dominator ethos. It matters little whether the top-down exercise of power is effected by autocrats, corrupt politicians, the priest-caste, the corporate sector or science community, the end point is the same: abnegation of the 'other,' be it an individual, social group, political agenda, religious beliefs, or intellectual orientation.

Figure 2. Aristotle's hierarchies of Governance depict forms of government relative to wealth, power and influence.



Medical-Industrial Complex

In the late 1950s President Eisenhower became increasingly concerned about what he called the 'military-industrial complex,' the huge armament industry that, in conjunction with the military establishment, had amassed immense political and economic power in the years after World War II. He warned of potential conflicts of interest between the private and public sectors in the realm of national defense and security.

In the 1960s a different kind of industrial complex emerged, this time in healthcare, with similar potential

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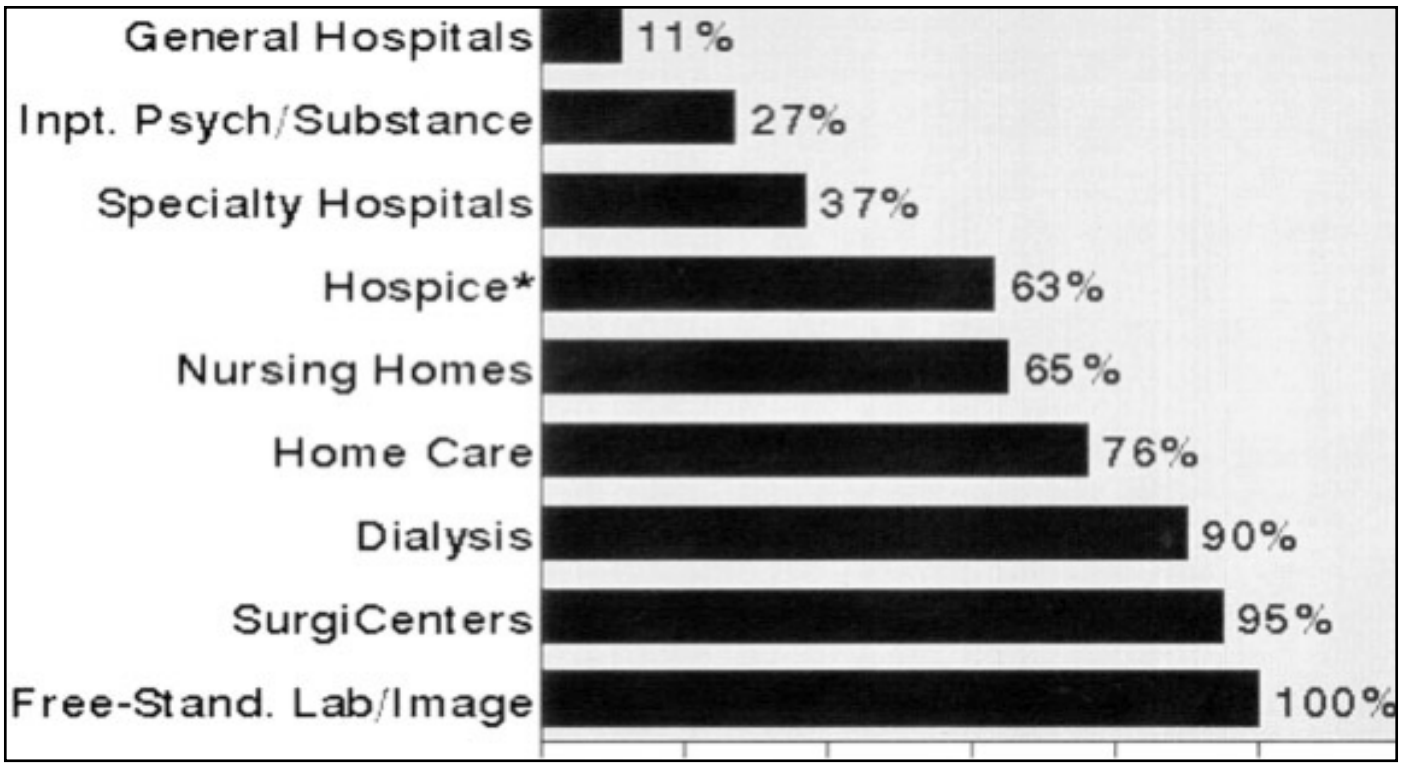
to blur distinctions between public and private interests and to shape public policy to its own ends. First coined the medical-industrial complex by John and Barbara Ehrenreich in *The American Health Empire: Power, Profits and Politics* (1970), it has expanded its reach from 5% of the GDP in the 1960s to almost 20%, with healthcare expenditures in 2020 of over $4 trillion.

Early writings on the subject focused on increasing commercialization within the healthcare system, i.e., the emergence of local investor-owned enterprises that sold health services for profit, such as proprietary hospitals as well as laboratory, hospice, long-term care, in-home care, dialysis, and psychiatric services. In a 1980 piece, physician Arnold Relman, editor of *The New England Journal of Medicine (NEJM)*, points to the rise of the 'new medical-industrial complex,' calling it the most important recent development in healthcare, and raises concerns over its implications for the future of organized medicine [40]. The change had occurred largely under the radar and attracted little attention except on Wall Street. This trend continued to snowball over the decades and now private entities control a disproportionate share of the healthcare economy (Figure 3).

Figure 3. The 'new medical-industrial-complex' in which private entities control a disproportionate share of healthcare. (Source: US Commerce Department, Annual Survey, 2016)



But Relman overlooked the intimate connection between privatization of the service sector and the rise of corporatism. He dismissed the threat of pharmaceutical and technology concerns claiming 'they have been around for a long time, and no one has seriously challenged their usefulness' and, moreover, 'there are no practical alternatives to the private manufacture of drugs and medical equipment'. While the foregoing may be true it doesn't imply that domination of the healthcare market by large corporations is the only possibility.

During the 1980s and 90s, as privatization reached a turning point, mergers and consolidations among locally-owned entities began to occur with increasing frequency so as to carve out market share and attain regional dominance. And regional entities soon merged or were bought out by larger entities to cultivate national markets. Corporatism in healthcare, ultimately, has its roots at the local level in the same way that cancers begin locally before spreading throughout the body.

As growth and consolidation proceeded, for-profit service industries developed symbiotic relations with established corporate entities in the pharmaceutical, technological, and insurance sectors. By the same token the expanding complex formed tangled relations with governmental

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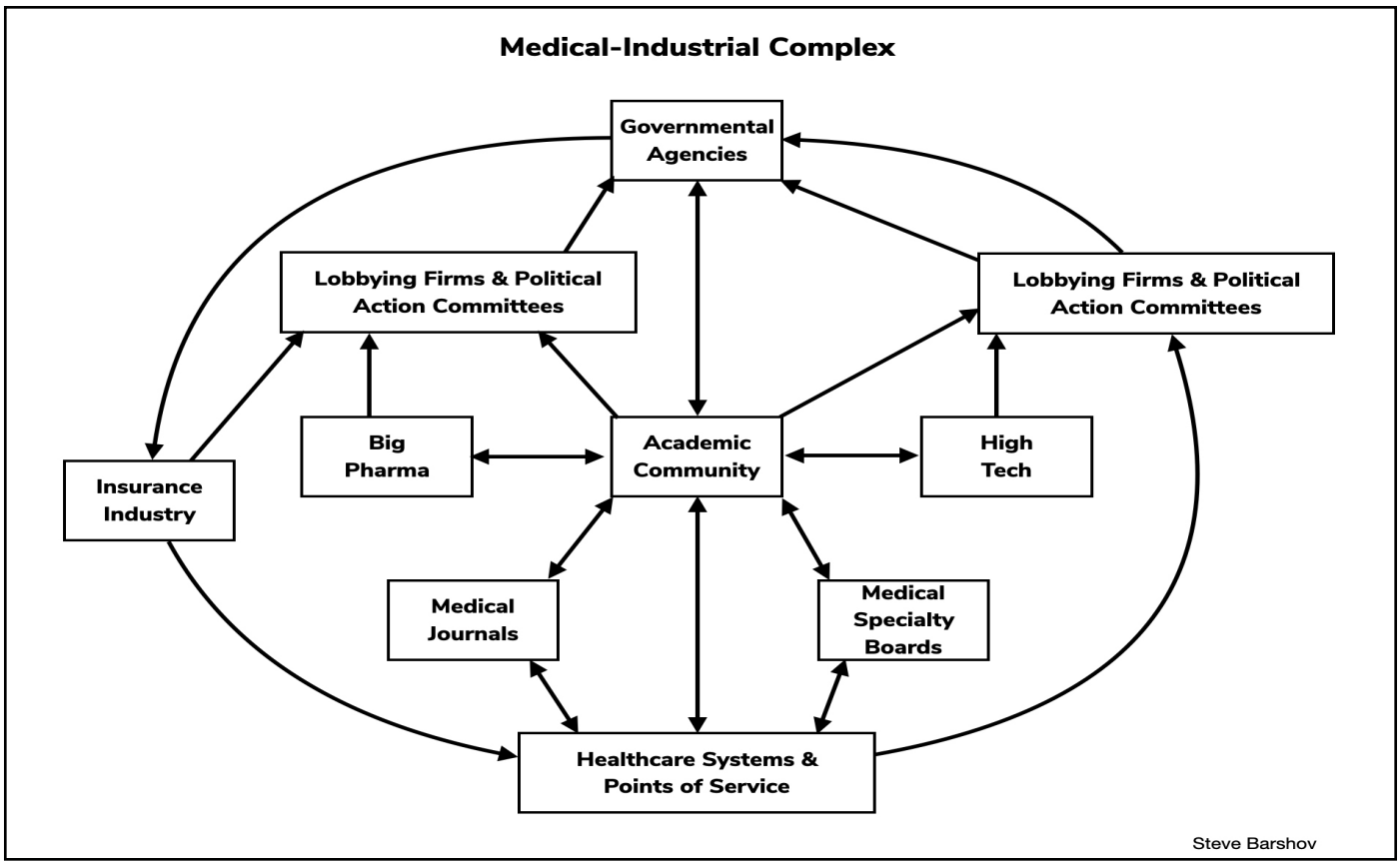
agencies, academic institutions, medical education, medical journals, specialty boards, and political bodies such as the American Medical Association. As in all dominator hierarchies, the rise of corporatization was driven by consolidation of private power and pursuit of profits.

As currently configured, the medical-industrial complex forms a three-tiered labyrinthine structure representing an interplay between three main stakeholders: the government, academics, and industry per se (Figure 4). Given that oversight of the complex, by design, is a governmental function, and that much of the funding ultimately derives from the public sphere, we situate governance at the top. The middle tier represents an amalgamation between the academic community and 'producer' industries such as Big Pharma and High-Tech sectors, while the bottom layer represents the 'service' component of the industry, i.e., hospitals, clinics, physicians and nurses and other points of interface with the public.

Figure 4. The medical-industrial complex forms a three-tiered structure of the government, academics and industry and the complex interplay between these three main stakeholders.



Observe the central role academics play in the dynamics of the dominator complex: they assert control over the generation and flow of science-based knowledge through investigational review boards that influence which clinical and laboratory studies are approved and, ultimately, receive funding; control the content of medical journals by acting as editors, reviewers, and opinion leaders who directly influence modes of practice at 'lower' points of service; populate and oversee medical specialty boards wielding influence over physician and nurse certification; populate governmental agencies or key committees that adjudicate policy and funding; sit on corporate boards or act as advisors for Big Pharma and High Tech concerns; own or engage in for-profit ventures even as their research is publicly funded. Many academics in fact serve in multiple capacities and freely circulate between the academic, governmental and private sectors. Academics play a key role in propagation of the dominator hierarchy which begins with the encounter between knowledge and

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profit.

In order to bring their product to market, drug and vaccine manufacturers depend on the intellectual resources and credibility of the academic community. But in order to generate sales and make money for investors, companies must have positive results in clinical trials. Academics, on the other hand, have a primary responsibility to maintain objectivity and uphold truth. Such opposing directives set the stage for potential conflicts of interest. This is where deep corporate pockets come into play.

A 2021 study reported in *BMJ* examined 538 studies to determine the extent of corporate influence in healthcare and found that the medical product industry has a wide sphere of influence throughout all sectors, including medical research, education, protocol development, drug selection, and clinical care. Beneficiaries of corporate largesse include not-for-profit hospitals, universities, physicians, medical journals and the government [41]. In 2020 Big Pharma lobbyists, already the largest sector of the lobbying industry, contributed a record $306 million to shape governmental policy decisions [42, 43].

The Physician Payments Sunshine Act requires for-profit biomedical entities to report all payments to physicians and teaching hospitals. A 2020 study found that 91% of US teaching hospitals received industry payments in 2018 totaling $832 million which included royalty payments from research partnerships, gifts and education [44]. Another study found that payments to physicians are also extremely common, especially in tech-dependent specialties such as cardiology and neurosurgery, and take the form of honoraria, consultancy fees and research funding [45]. A 2019 study found that among top-tier medical journals 63.7% of US editors received industry-related payments with a mean annual of $55,157 [46]. Other studies confirm the widespread nature of this practice [47]. Even supposedly impartial reviewers for journals have been found to receive industry payments [48]. A 2022 study found high rates of industry compensation and low rates of disclosure among study authors in high-impact publications such as *NEJM* and *JAMA* [49]. Studies peg financial conflicts of interest among biomedical researchers at a minimum of 30%. Researchers with conflicting interests are more likely to report positive results from studies and to favor their industry partners [50, 51].

In 2004 the National Academy of Sciences (NAS) issued a conflict of interest policy requiring members to disclose potential sources of bias that could be construed as prejudicial [52]. While disclosure policies have been implemented in academic medical centers and in many scientific journals a large number of researchers fail to report conflicts of interest which led the NAS to issue stricter guidelines in 2017 [53]. All the same, studies indicate that between 43% and 69% of study authors fail to disclose conflicts of interest [54].

Perhaps the most brazen example of conflict of interest involves pharmaceutical companies involved in the manufacture of opiates, which poured tens of millions of dollars into cultivating webs of influence among health professionals, research universities, hospitals, health agencies, and politicians to boost opioid sales. Corporations sought to expand opioid use beyond cancer patients and into the lucrative acute and chronic pain markets. Part of the strategy included minimizing the risk of addiction by labelling such concerns as 'opiophobia' [55].

According to a suit launched by the Massachusetts Attorney General, Purdue Pharma, maker of OxyContin, funneled vast sums into dozens of institutions in Massachusetts alone, including establishment of a pain center at Massachusetts General Hospital. Academic institutions continued to accept Purdue gifts even after the company pleaded guilty in 2007 to misleading physicians and the public about addiction risks [56]. The opioid crisis continues to cost up to one hundred thousand American lives and an inestimable financial burden annually.

Conflict of interest takes a multitude of forms. During the pandemic, Fauci established the COVID-19 Treatment Guidelines Panel to make recommendations on effective treatments [57]. At least sixteen members of the panel had financial ties to Gilead, manufacturer of the antiviral agent remdesivir, of which seven failed to disclose the conflict of interest, including the three co-chairs. To complicate matters, H. Clifford Lane, MD, one of the co-chairs, was a co-author of a controversial study published in *NEJM* that gave highly favorable reviews to remdesivir despite the fact that it had failed in other clinical trials [58, 59]. It is hardly surprising this esteemed panel of experts chose remdesivir as the preferred COVID-19 treatment despite its marginal benefit or its exorbitant cost of over $3000 [60]. In spite of such chicanery the WHO still advised against the use of remdesivir. As a fait

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accompli Fauci's expert panel nixed effective medicines such as hydroxychloroquine and ivermectin both of which are widely available and a tiny fraction of the cost of remdesivir [61-63].

If private interests have potential to subvert scientific objectivity and credibility as well as adversely impacting public policy then recent trends raise even more eyebrows. About 70% of clinical trials now conducted to obtain regulatory approval for a drug, vaccine, medical device, or to track safety after approval, are sponsored by industry [64-67]. This has prompted debate as to the extent of corporate influence over design, implementation and interpretation of clinical trials. 'I don't think the system we have is balanced the way it should be', commented physician and former FDA commissioner Robert Califf, 'but it's been that way forever' [68]. Not surprisingly corporate malfeasance came to the forefront during the pandemic.

Both Pfizer and Moderna conducted their own COVID-19 vaccine trials and, to that end, were urged by the FDA in October, 2020 in a non-binding recommendation to implement a clinical trial design to enable ongoing assessment of vaccine efficacy and safety. The companies argued that the recommended design was 'onerous' and overly complicated and, instead, altered protocols that included allowing study participants access to their data [69, 70].

Diana Zuckerman, president of the National Center for Health Research, argued that failure to implement the recommended design resulted in loss of valuable data and, moreover, that the FDA could have demanded the companies adhere to the guidelines in order to receive vaccine approval. Consumer representative Sheldon Toubman, lawyer and member of the FDA advisory panel, cited a paucity of evidence as to whether the vaccine is effective in preventing severe COVID-19 infections. And based on how other vaccine trials were conducted, he raised concerns as to whether the six-week follow-up period was sufficient to reliably assess the safety of these novel and untested preparations.

During the implementation phase of the vaccine trial things went from bad to worse. In November, 2021, a stunning whistleblower exposé appeared in *BMJ* alleging improprieties involving not only unblinding of subjects but falsification of data, using inadequately trained personnel, and unacceptable delays in follow-up of adverse event reports [71]. The whistleblower who brought forth the allegations had repeatedly raised concerns about lapses in protocol and, finally, was fired. Data subsequently obtained through a Freedom of Information Act request indicate adverse events from the vaccines far exceeded original estimates. By late February, 2020, for example, of the 274 pregnant women who had received the vaccine 27.4% developed serious adverse clinical reactions [72]. In late April this data was sent to both the FDA and CDC which, nonetheless, continued to issue glowing safety reports.

Alongside the rise of corporatism in recent decades has been an increased emphasis on evidence-based medicine. But it is sobering to realize that a large proportion of evidence in the medical literature is driven by corporate imperatives to turn a profit. What is fact? What is spin? A recent review of 1567 health interventions labelled as effective by the Cochrane Review between 2008 and 2021 were reevaluated on the basis of high-quality evidentiary standards and only 87 (5.6%) met the criteria [73]. Another study evaluated drugs approved between 1999 and 2012 and found that nearly one-third of new drugs were no better than drugs already in use while some were worse [74]. Corporate incursions into medical research compromise integrity and erode scientific credibility. Caveat emptor.

Disinformation Playbook

The corporate undermining of scientific research and consensus has been a consistent theme in a wide range of public health issues over the past half-century: the dangers of tobacco smoke; the adverse effects of refined sugars; the hazards of atmospheric pollutants like hydrocarbons and lead; the leeching of pesticides and herbicides like DDT, glyphosates and atrazine into the ground water; the risks of electromagnetic fields from power lines or the internet. In all cases, rather than engaging in open dialogue and allowing evidence to come forth, the corporate sector resorted to a range of tactics intended to obfuscate truth, sow seeds of doubt, sway public opinion, and stonewall corrective action. In addition to the obvious effect corporate lies and deception have on the integrity of scientific discourse such tactics have polarized the American public to a degree unrivaled in almost any previous epoch.

The term cartel evokes images of illegal drug trade or multinational oil coalitions but, in a broad sense, denotes

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groups of independent producers who band together to control the production, distribution, and pricing of a shared commodity within a market sector. Implicit in the term is the ability to impose detrimental consequences on the market so as to gain advantage. This is a hallmark of all dominator hierarchies, whether political or economic, that seek to enforce their ideologies. The medical-industrial complex, by any stretch, falls into this category.

In a responsibly functioning pluralistic system, when research reveals potential harm from a commercial product the science community speaks out and additional inquiry ensues to corroborate or refute the danger. If risk is present then lawmakers enact legislation to protect the public. End of story. In response to this system of checks and balances, however, corporations have devised countermeasures, the 'disinformation playbook,' to subvert the integrity of evidence-based scientific inquiry and obstruct governmental oversight [75, 76]. Such schemes usually entail a multi-pronged approach.

The primary strategy is to manufacture uncertainty among the public. This involves spreading false doubts about the potential harm of a product or minimizing its danger as in the case of OxyContin. Public relations firms are often recruited to shape social attitudes. Articles are published in select media outlets to legitimize the corporate point of view. Political lobbyists are engaged to elicit support among legislators. Such dominator tactics amount to a full-scale blitzkrieg to gain social and political leverage.

Through their connections with the academic sector, corporatists seek to 'buy' credibility. They use various forms of payment and reward to exploit the perceived integrity of academic institutions in order to advance their agendas and gain legitimacy. Corporate financial support has been used to cultivate academic partnerships, endow chairmanships, fund faculty research positions, and even establish entire institutes. At the same time, while enhancing their social status through strategic generosity, they conceal conflicts of interest with industry-affiliated scientists who publish supportive research or make favorable public comments. Corporations work covertly through secondary channels to advance their agenda while shielding themselves from scrutiny.

Another strategy involves calling into question the credibility of potentially damaging research: attack the methods or results of a study, challenge its interpretation, supply contradictive data, or advance an alternative narrative. Whether the rebuttals are factual or not is irrelevant, the corporation still wins. The purpose is to muddy the waters and insidiously shape the beliefs and opinions of scientists, physicians, and the public [77, 78].

A recent meta-analysis found striking variations in the reporting of beneficial outcomes with hydroxychloroquine (HCQ) between the US and the rest of the world. Of 68 studies originating in the US, 39 (57.4%) were unfavorable while only 7 (10.3%) reported favorable results. Of 199 studies originating elsewhere, 66 (33.2%) were unfavorable, 69 (34.7%) favorable and 64 (32.2%) indeterminate. Studies with at least one US main author were 20% more likely to report unfavorable results [79]. Such hidden biases contribute to the spread of misinformation which, in turn, is the result of the planting of disinformation by corporate and academic actors.

In May of 2020 *Lancet* published a meta-analysis of 96,000 hospitalized COVID-19 patients from 671 hospitals across the globe by Harvard cardiologist Mandeep Mehra et al which found HCQ yielded no benefits and was supposedly associated with increased risk of cardiac arrhythmias and death [80]. Within days several large clinical trials involving HCQ were discontinued. The article was cited by Fauci to support his claim that these substances were ineffective. But discrepancies in the report raised eyebrows. The data had been collected by Surgisphere, a little-known Chicago company run by one of the authors of the study. When the data was requested for independent review the company declined and *Lancet* subsequently retracted the article [81, 82]. In addition to research scandals there have been an unprecedented number of journal retractions during the pandemic [83, 84].

Faced with significant COVID-19 vaccine hesitancy and anti-vax sentiment the medical-industrial complex launched a campaign in late 2020 to sway public opinion. A large percentage of this funding came from government coffers. In Spring, 2021, clinical studies began to appear in high-impact journals supporting industry-run trials and affirming vaccine safety. Some of these were clearly intended to whitewash vaccines and shape public opinion. The most blatant example of data-doctoring, eerily similar to the fraudulent Pfizer study conducted during the same time frame, was published by *NEJM in* June, 2021 [85].

In a study intended to evaluate vaccine safety during pregnancy, Shimabukuro et al. followed outcomes in 3958

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vaccinated pregnant women between mid-December 2020 and the end of February 2021. During the two-and-a-half-month period 827 women completed their pregnancy of which 712 (86.1%) were live births and 115 (13.9%) pregnancy losses. Of the pregnancy losses, 104 were spontaneous abortions the vast majority of which (92.3%) occurred before 13 weeks of gestation. Upon review of the data, however, 700 (84.6%) of women weren't vaccinated until the third trimester, long after the spontaneous abortions would have occurred. Nonetheless, authors included these 700 third-trimester vaccinations in the denominator when they calculated the spontaneous abortion rate. Based on their statistical sleight-of-hand, authors pegged the spontaneous abortion rate at 12.6% (104/827) when, in fact, it was actually 82% (104/127). This astonishing miscarriage rate is equivalent to the efficacy of the so-called abortion pill, RU486, which carries an FDA black box warning to alert consumers to major drug risks. And yet Shimabukuro et al. concluded there were no obvious safety concerns.

This is disinformation plain and simple and cannot be written off as accident. There were 21 named authors on the study, 8 of whom were physicians, including 3 Ob-Gyn specialists, and others with expertise in public health and epidemiology. It is inconceivable that an error of this magnitude could escape the scrutiny of such a stellar cast. And how could it have been overlooked by the *NEJM* editorial staff and reviewers unless by intention? Provocatively, all 21 authors report affiliations with either CDC or the FDA. And NEJM, the flagship journal of the medical-industrial complex, has taken a strong pro-vax stance that can hardly be called objective. Shimabukuro's thinly-veiled attempt to downplay the risks of COVID-19 vaccines and mitigate vaccine hesitancy is yet another research scandal laden with conflicts of interest and intent to deceive.

In our recently completed analysis of data from the Vaccine Adverse Event Reporting System (VAERS), we document staggering increases in multiple adverse events related to the COVID-19 vaccines when compared to influenza vaccines: 1000-fold increase in menstrual irregularities including abnormal uterine bleeding; 50-fold increased risk of miscarriage; 100-fold increase in fetal chromosomal abnormalities; 90-fold increase in cystic hygroma; 40-fold increase in fetal cardiac disorders; 50-fold increased risk in fetal cardiac arrhythmias; 40-fold increases in fetal cardiac disorders; 200-fold increased risk of fetal cardiac arrest; 70-fold increases in placental thrombosis; 35-fold increased risk of fetal demise. Such counterfactual evidence flies in the face of Shimabukuro's claim that the vaccines are safe during pregnancy.

Gaslighting is an insidious form of manipulation intended to gain psychological control wherein individuals are fed false information to skew their perception of reality and render them incapable of making informed judgments. At the broad social level such practices amount to propaganda. The very act of communicating in such fashion implicates a dominator hierarchical power dynamic in which information flows in top-down manner as seen in autocratic and/or oligarchic systems rather than originating as true dialogue among equals. Equals do not seek to manipulate or gain control over the other.

Such asymmetric distribution of power has led to various forms of harassment, coercion, attempted silencing and social bullying of individuals who publish research that runs counter to the corporatist narrative. Targeted individuals have been accused of personal and/or scientific misconduct, threatened with potential litigation, loss of licensure, board certification and/or ability to maintain a livelihood. Such campaigns are usually conducted through secondary channels while the corporate and academic puppet-masters remain in the background pulling strings. Such ad hominem attacks have become disturbingly more frequent during the pandemic.

In recent months professional bodies that govern medical certification such as the American Board of Obstetrics and Gynecology, American Board of Internal Medicine, Federation of State Medical Boards, American Board of Medical Specialties and American College of Nursing have banded together and issued threats against physicians and other health care providers for dissemination of COVID-19-related 'misinformation' [86-89]. Their edicts do not specify exactly what constitutes misinformation but seem to connote evidence or statements that would contribute to vaccine hesitancy. In this sense misinformation applies to any view contrary to that propagated by the medical cartel, i.e., the various governmental, corporate, academic, and healthcare stakeholders, which seeks total information control pertaining to the pandemic not to mention the lucrative vaccine and therapeutics market [90].

In June, 2021, the American Board of Internal Medicine

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notified physicians Peter McCullough and Pierre Kory, two pioneers in the development of early treatment protocols for COVID-19 infection, that they faced possible disciplinary sanctions for 'providing false and inaccurate information to patients' [91]. McCullough, cardiologist and epidemiologist, with hundreds of peer-reviewed articles in his résumé, published the first early treatment protocol for COVID-19 in August 2020, and is an outspoken COVID-19 vaccine critic. Kory, critical care specialist, former division chief at University of Wisconsin Health Center, and president of Front Line COVID-19 Critical Care Alliance, has published numerous articles in support of early treatment with medicines such as ivermectin. Dozens of physicians and scientists across the country with similar leanings have been publicly vilified in legacy media outlets for spreading COVID-19 'misinformation' [92]. How different is this from suppression of dissent by autocratic regimes under the sway of Chicago School economics?

The medical-industrial cartel uses governance bodies like the American Board of Internal Medicine to enforce their agenda and control the market by promoting vaccines as the only option for COVID-19 in spite of a plethora of evidence in support of other safe and effective treatments. Through their Machiavelian web of disinformation they use physicians and healthcare systems to carry out their insidious scheme to prevent individuals from making autonomous and informed decisions regarding treatment options.

By foisting dangerous experimental vaccines and costly ineffective drugs like remdesivir on the populace, corporatists placed physicians in the same ethical dilemma as the academic research community. Physicians are bound by a moral code that mandates safe and effective treatment of sickness: first do no harm. Physicians' moral obligation began in early 2020 at the start of the pandemic and not in early 2021 with release of the vaccines. By that time resourceful physicians had already discovered effective treatments that were substantiated in clinical studies published in peer-reviewed journals. Based on the abysmal showing of the vaccines and remdesivir, the early treatment protocols must be regarded as the standard of care for all COVID-19 infections. This is how medical science has functioned for centuries before it was usurped by the purveyors of disaster capitalism.

Disaster Capitalism Revisited

Over the past half-century, the corporatist ideology has spread like a cancer across the globe adversely impacting countless lives while concentrating vast wealth and power into the hands of a few. In their earliest form corporatist takeovers were engineered through violent political coups effected by autocratic strongmen but, in recent decades, disaster capitalism has assumed a more benevolent façade in which natural or man-made crises are exploited by the corporate sector, ostensibly for the public good, to amass power and wealth. Corporatist interventions are invariably accompanied by massive transfer of public wealth and resources into private hands. Such overt dominator tactics have culminated in the ubiquitous rise of pathologic social hierarchies such as plutocracy, governance by the wealthy, and kleptocracy, in which malefic actors use power to appropriate public resources into the private domain.

Over the past five decades, parallel to the rise of the corporatist state in the US, we observe a meteoric rise of the medical-industrial complex which has mushroomed from what sociologist Paul Starr called a 'cottage industry' to one of the largest sectors in the economy, now comprising almost 20% of the GDP. Its tentacles reach deeply into the governmental and academic sectors which, in times past, served as moderating influences to counter the rapacious impulses of the corporatist agenda.

We provided disturbing evidence of widespread malfeasance on the part of the medical-industrial complex during the COVID-19 pandemic which, to date, has adversely impacted tens of millions of Americans and resulted in over a million deaths. During the pandemic plundering and profiteering was rife, with huge revenues raked in by Big Pharma, vaccine producers, insurance companies and large healthcare systems among others, the large burden of which was funded by taxpayer dollars.

We documented collusion between the corporate sector, governmental oversight bodies, and the academic community including manipulation of clinical trials, deliberate falsification of data, and publication of blatant disinformation. Such collusion involved prestigious universities and health centers as well as top-tier medical journals necessitating, in some cases, retraction of published materials.

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We also pointed to deliberate suppression of alternative points-of-view not only by mainstream science and the mass media, but by governmental agencies like the NIH and CDC, whose duty is to protect the public interest. Medical specialty boards were enlisted to enforce compliance with the corporatist agenda. Evidence related to early treatment protocols suggests that the overwhelming burden of suffering and death was preventable had obstructive efforts not been vigorously imposed.

In the next part of our series we examine in greater detail the tragic mishandling of the COVID-19 pandemic, from its very beginning to our current dilemma, and reveal a mounting trail of evidence incriminating enforced social policies and the disastrous vaccine initiative.

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