
Reflections

Conservatives, Cowardice, and Health Care

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CALEB HENRY

On December 26, 2017, RaDonda Vaught lived every nurse’s nightmare by accidentally killing a woman. Instead of giving the prescribed sedative, Vaught mistakenly administered a powerful, paralyzing drug. This drug paralyzed the patient, who then experienced all the sensations of dying without being able to move. The patient, who was on the way to recovery, instead suffered a horrifying death.

Vaught immediately told her Vanderbilt University Medical Center supervisors what she had done, and Vanderbilt administrators then did what some believe is common. They broke the law by not reporting the medical error, instead officially declaring the death to be of natural causes. A year later, an anonymous tip led to a Centers for Medicare and Medicaid Services investigation. Vanderbilt Medical Center was eventually required to tell CMMS how they would fix their systemic failures, which had contributed to the death (Kelman 2022).

However, the nightmare was just beginning for RaDonda Vaught. The Tennessee Department of Health reversed its decision made a year earlier and revoked her nursing license, while a Tennessee prosecutor successfully prosecuted Vaught for criminally negligent homicide and abuse of an impaired adult. Vaught’s

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unsuccessful defense pointed to systemic failures, such as a flawed electronic communications system that required nurses to constantly override warning notices. Vaught has been sentenced to three years of probation, but her life has irrevocably changed. Vanderbilt University Medical Center was not criminally charged (Kelman 2022; Timms et al. 2022). For a medical perspective on the case, watch Zubin Damania’s podcast (2022).

The Vaught case shows that Americans who are frustrated with our flawed medical system can make things worse, in this case, by encouraging personnel to hide medical errors. In his Lyceum Address, Abraham Lincoln warned that a crisis can create opportunities for ambitious men (Lincoln 2002). Ambitious politicians recognize that America’s overly expensive healthcare costs are driving employers abroad (Laffer, Van Horn, and Fisher 2022, 10). In this vein, the recent passage of the so-called Inflation Reduction Act, which extends premium subsidies in the Affordable Care Act’s marketplace and lowers prescription drug prices for Medicare beneficiaries, reveals that progressives see this problem and remain committed to national health insurance and healthcare as their solution.

Libertarians and conservatives fail to sufficiently understand the pathologies within our medical system. By refusing to meaningfully analyze them, they are ceding the public policy realm to centralizing progressives. Conservatives, who have largely failed to “repeal and replace” Obamacare, must intellectually and politically prepare for this debate by better understanding the benefits of the progressive critique and the possibilities of a market-based reform.

The Progressive Critique

Peter Swenson’s *Disorder: A History of Reform, Reaction, and Money in American Medicine* (Swenson 2021) is an excellent place to start. Swenson desires “the planning of preventive action to protect citizens’ constitutional rights to life, liberty, and the pursuit of happiness” and looks at American medical history through the prism of the American Medical Association. The AMA founders were progressives who emphasized preventive medicine, whereas the contemporary, conservative AMA focuses on paid treatment. This fascinating book reveals how today’s progressive approach to healthcare reflects early progressive concerns.

Swenson admits that economists such as Milton Friedman and George Stigler argued that medical licensing and education reforms were doctors’ self-interested creation of barriers to entry (Friedman 1962; Stigler 1971; Hamowy 1979). In contradistinction, Swenson argues that the early AMA was driven by progressive ideals in a period in which many medical practitioners engaged in unethical and harmful behavior because of market pressures.

America’s early medical history can be shocking. Many doctors unnecessarily prescribed the removal of women’s ovaries, causing critics to pointedly ask why this

“mutilation of the sexual system” was not similarly applied to men. Drug financiers funded medical journals through advertisements, and it was often claimed that the drugs they promoted could solve anything. Dr. Kilmer’s Female Remedy would cure “nervous or sick headache, stomachache, spineache, bloating, internal heat, scalding urine, chronic weakness, bearing down or perversions incident to life change, uterine catarrh, suppressed or painful periods . . . and dull tired looks and feelings” (Swenson 2021, 22). The ingredients were secret, which meant that no one knew the drugs were hokum. Because teething was viewed as a medical crisis, some doctors prescribed combinations of morphine, chloroform, and chloral hydrate to ensure that babies slept through their infancy.

Some states required that mothers give birth with doctors present instead of midwives, resulting in an increase in infant mortality. Surgeons paid doctors who referred patients to them, drug pitchmen bamboozled ignorant doctors, and because everyone was paid for services rendered, very few focused on overall human health. Whereas London installed a water filtration system in 1829, Washington, D.C., did not get one until 1905. Presidents Harrison, Polk, and Taylor might have died because the White House water supply passed through a marsh full of human excrement.

Early progressives fought to prohibit drug financing of medical journals, decrease the supply and improve the quality of medical schools, and prevent the spread of disease. As these progressives viewed it, they struggled against America’s constitutional principles, local democracy, and capitalist players. Progressives argued that farm animals had more protection than did children. The Bureau of Animal Industry “investigated and acted against blackleg, foot-and-mouth disease, glanders, swamp fever, Texas fever, and many other exotic-sounding diseases most Americans had never heard of” (Swenson 2021, 164).

As is often the case for progressive scholars, hookworm plays an important role. State politicians ignored poor children in the South who suffered from hookworm, instead focusing on parasites that affected farm animals. By 1909, the military’s battle against yellow fever when building the Panama Canal finally revealed the importance of preventive public healthcare. Swenson finds historian John Ettlting to be persuasive when John D. Ettlting argues that Rockefeller altruistically funded programs like that which helped end hookworm in the South (Ettlting 1981). However, Swenson suggests that Florida’s example is more helpful. Florida refused Rockefeller’s philanthropic offer, instead preferring to fund its own health authority.

The AMA experienced a political transformation in the 1920s when its progressive leadership was replaced with conservatives. Swenson admits that the latter were probably more representative of America’s doctors but argues that both leadership groups were more extreme than the general membership. The AMA later famously hired then-actor Ronald Reagan to speak against Medicare legislation.

Jonathan Cohn picks up where Swenson leaves off, in *The Ten Year War: Obamacare and the Unfinished Crusade for Universal Coverage*. In this book, Cohn summarizes the history surrounding the Affordable Care Act. Cohn acknowledges his own progressive bias and then confirms it. One paragraph after praising a Democrat's political use of a family member's medical story, he downplays a Republican who "defended himself the same way many other Republicans did"—by describing a family member's medical story (2021, 324). "Experts" present the progressive perspective, but "experts" rarely argue the alternative. Particularly humorous for those in higher education, he describes Federalist Society founders as challenging "what conservatives perceived as liberal hegemony over both academia and the courts" (216).

Regardless, the book is a reminder of progressives' commitment to healthcare reform. Bill Clinton's disastrous healthcare reform attempt did not end their commitment. President Barack Obama's introduction of the Affordable Care Act (ACA) led to Republican Scott Brown's stunning win in Massachusetts's special election for U.S. Senate, but Democratic leadership passed the ACA regardless. When have conservatives shown such commitment?

Obama administration officials wanted reform but had differing motivations. Some were primarily concerned with universal coverage, whereas others, like director of the Office of Management and Budget, Peter Orszag, were concerned with cost management. Obamacare showed how progressives could work with the medical industry. The "Cornhusker kickback" and the financial double counting remind us how the healthcare sausage was made.

These histories of the AMA and Obamacare reveal today's progressive assumptions on healthcare. Market pressures lead medical practitioners to engage in unnecessary medical procedures and politically mobilize against preventive medicine that might hurt their revenue. Market-based individual insurance plans would harm higher-risk individuals who would not find coverage. Ignorant consumers require expert guidance. Most importantly, property rights must bow before healthcare.

Franklin Roosevelt put aside national health insurance to enact Social Security, but in his Commonwealth Club Address he argued, "By no other means can men carry the burdens of those parts of life which, in the nature of things afford no chance of labor; childhood, sickness, old age. In all thought of property, this right is paramount; all other property rights must yield to it" (Roosevelt 2009). Modern progressives expand upon this argument. Swenson references progressives who argue that public health includes firearms, nuclear weaponry, environmental threats, noise pollution, and light pollution.

Cohn interviewed the major players who see Obamacare as a step toward universal healthcare and a great moment in American political history. Conservatives will obviously disagree, but more interestingly, so do hard left political activists. Timothy Faust's (2019) *Health Justice Now: Single Payer and What Comes Next* represents this activist fury.

Faust differentiates healthcare from health insurance. Access to healthcare accounts for only one-fifth of the difference in healthcare outcomes. Therefore, Faust argues that healthcare necessarily involves housing, food, environmentalism, education, income, and mental health. Faust has the zealot's passion for engaging in political warfare. A representative, but frankly disgusting, example is his analogy of America's drug delivery system. Faust graphically compares it to the human waste delivery system in a fashion that presumably thrills the activists as much as it revolts this author. Subtlety is not Faust's strength.

Faust's arguments are increasingly found on American campuses: building more housing will not affect housing prices, "culture of poverty" arguments represent "lazy thinking," "skin in the game" models are fundamentally false, and so forth. Racism, sexism, and poverty apparently underlie any statistics he disagrees with. He praises other countries' healthcare systems while attacking cost-sharing plans. (Yet most developed countries require higher out-of-pocket payments than do American plans.)

Faust's book is important for two reasons. Based on my experience in the classroom, this is likely to be the kind of book that is commonly read by college students. Indeed, I have had a couple of college students refer to it in conversations. More importantly, however, Faust faces up to two underlying issues that Swenson and Cohn elide.

Faust views our current system, including Obamacare, as fundamentally evil. The medical industry did not fight Obamacare, because it had been paid off. Bernie Sanders famously praised a Mercatus Center paper which said that Sanders's Medicare for All plan could save \$2 trillion over ten years (Faust 2019, 4). The details are complicated, but Bernie Sanders understands that expanding Medicare requires radically cutting expenses.¹ Many experts claim that America spends one out of every three healthcare dollars on corruption, waste, or misspending (Silver and Hyman 2018, xiii). Faust argues that rationing healthcare would reduce these inefficiencies, allowing for broader healthcare coverage.

Faust also explicitly argues for radically expanding the definition of healthcare. Progressives have argued that healthcare is more than medical services. After all, hookworm is best prevented with footwear and proper sewage treatment. Faust goes further by arguing that the right to healthcare apparently includes everything that affects health. FDR redefined the Founders' language of freedom to include progressive goals. Faust largely subordinates all rights to healthcare, which then extends to all of life. This is simply politics redefined as public health.

Of course, there is nothing new about this idea. There are relatively few logical leaps from Michelle Obama's "Let's Move" childhood food campaign to recognizing the importance of pregnant women's food intake. If unborn children can taste the

1. Medicare's trustees, of course, project that it will go bankrupt in 2028 as it is (Antos 2022).

food their mothers eat, then equal opportunity requires radical communal control.² This has all been covered in Plato's *Republic*; radical equality requires state control of children rather than familial. Similarly, the expansion of healthcare to include mental health was anticipated by Jean-Jacques Rousseau.

Every professor who has been reported for creating an unsafe space knows the importance of continuing this discussion about political philosophy. Similarly, many parents now see regulatory demands to “follow the science” as nothing more than political pablum repurposed for political control. The argument for limited government is increasingly necessary, given progressives for whom the cure for the ills of centralized administration is always more centralized administration. However, Alexander Hamilton knew that efficient administration was vital for republican governance. Political philosophy is not enough.

Conservative Response

COVID-19 policies aside, there is a legitimate healthcare crisis. Cohn correctly notes that conservatives have often avoided healthcare policies, instead preferring to mobilize voters by arguing against Democratic proposals. Conservatives and libertarians must honestly study American medical history to then grapple with the perverse incentives within our medical system.

Werner Troesken's *The Pox of Liberty: How the Constitution Left Americans Rich, Free, and Prone to Infection* (2015) should be read in conjunction with Swenson's book. Troesken notes that the American founders prioritized political and economic goals over health policy goals. This led to a different perspective on health programs. American health regulations in Cuba and Puerto Rico drove out smallpox before this happened in the United States because American political freedom allowed citizen resistance, which Cubans and Puerto Ricans did not enjoy.

However, there is no simple connection between politics and public health outcomes. The Constitution's Commerce Clause obstructed quarantines, but local communities did well when it came to water sanitation. Indeed, America's creation of public water systems might have been the largest public investment in American history. Furthermore, citizen revolts protected minority groups, who were often targeted using health code regulations. For example, prominent antivaccination activist Lora Little also successfully blocked Oregon from passing a eugenics-inspired mandatory sterilization law (Troesken 2015, 75).

Troesken argues that public health policies should be studied in light of political institutions, capital investment in public health, and mortality transitions. Because

2. Federal programs inevitably create incentives. A reasonable approach to healthier eating would seek to incentivize better choices. I find most of the recommendations given by the Bipartisan Policy Center to be persuasive (Frist, Glickman, and Veneman 2018). I remain skeptical about plans to regulate grocery stores.

governments had previously defaulted on the debt that funded railways, American capitalization of local water projects required state constitutional amendments, to protect creditor interests. The debt-financed water systems then led to the largest expansion of government in American history.

Troesken is particularly good at countering progressive claims that privately funded water systems would insufficiently fund water filtration. In fact, private systems were more likely to have water filters. Furthermore, private water systems facing threats of government cooption would naturally avoid further capital projects. Some cities would use regulation to drive down the value of the private water companies prior to seizing the companies via eminent domain. Politicians are often tempted to prioritize public health infrastructure at the expense of political and economic rights. Unfortunately for these politicians, increased political control will not fix the issues facing American healthcare.

As John Goodman has often noted, the healthcare industry is a complex system. “These systems are so complicated that no one person can ever fully grasp everything that is going on” (2012, 1). There is no market clearing price, which results in healthcare competitors who don’t compete on either price or quality. As has been well put, “Imagine if the price of gas varied by pump between \$2 and \$12 a gallon, and drivers didn’t know what they owed until after they filled up and drove off” (Laffer, Van Horn, and Fisher 2022, 9). After the passage of the Affordable Care Act, how should we make sense of today’s medical industry?

Charles Silver and David Hyman’s *Overcharged: Why Americans Pay Too Much for Health Care* is an excellent introduction. They correctly critique America’s reliance on third-party payers and political manipulation. Consumers who rely on insurers, whether private or public, have no reason to pay attention to costs—and so they don’t. With governments turbocharging healthcare spending, few have the inclination or authority to judge whether a healthcare procedure or test is worth the cost. As Medicare and Medicaid costs spiral upward, the authors expect eventual cuts to these programs. Because these cuts will ignore what drives prices, the cuts will disproportionately affect lower-income people. We should instead change incentives, lowering prices for everyone.

Healthcare incentives are flawed across the industry. Those who get paid for delivering drugs or services will inevitably deliver more drugs and services. Similarly, American drug companies take advantage of patent laws to increase drug prices. By gaming patent laws for so-called orphan drugs, finding ways to minimally improve drugs to lengthen their monopoly pricing power, and paying other drug companies to delay offering generic alternatives, drug companies have single-mindedly pursued profits at the cost of the common good. The stories are legion.

Silver and Hyman, like others, describe EpiPen as a typical example. EpiPen is a decades-old drug that helps with allergic reactions. The company that made the drug obtained a patent on the injector and then increased the price of the drug

450 percent over a two-year period. By using lawsuits to drive away generic competitors, they were able to charge a monopoly price. The same EpiPen that sold in America for \$600 sold for about \$80 in Canada. (Drug companies often offer coupons for low-income patients, but this is simply used to cover co-pays, thereby obtaining monopoly fees from the insurance companies. Self-pay patients have sometimes found that they are ineligible for these coupons. To add insult to injury, some companies funneled “discounts” through nonprofits, thereby writing off the co-pays.)

Looking back on the EpiPen story reveals that this is, indeed, a typical example. Once there was a competitor, the price of EpiPen started dropping (R. March 2018). If competition is the goal, then Food and Drug Administration (FDA) regulations are likely to be the obstacle. In fact, the answer to the EpiPen crisis could have been as simple as allowing it to be purchased over the counter (Graham 2016).

Silver and Hyman argue that even generic drug companies appear to be using a tit-for-tat strategy. When one company raises drug prices, the others quickly follow. Drug companies also engage in an “evergreening” strategy, making small changes to an existing drug to extend their effective monopoly. Since Medicare pays for around a third of all retail drugs, competition is largely irrelevant for retail drug prices. Controlling healthcare costs requires competition, which in turn requires price transparency (Laffer, Van Horn, and Fisher 2022). It is not surprising that self-interested companies fight against price transparency.

I assign the classic *Plunkitt of Tammany Hall* (Riordon 1995) to my students. The book’s delightful description of Tammany Hall corruption helps students understand the seedy side of politics. Similarly, the authors take great delight in describing how easily Medicare has been fleeced by entrepreneurial crooks. Numerous doctors, surgeons, pharmacists, and hospitals have been corrupted by the realization that they are paid only for services delivered. Indeed, some cocaine distributors decided to go into healthcare fraud, because it was more lucrative and less dangerous. One person was so successful in his healthcare fraud that he franchised it to others (Silver and Hyman 2018, 233, 237). America is indeed the land of opportunity!

Patients often receive tests and procedures that, at best, may be minimally helpful. In a famous study, researchers discovered that patients with severe heart failure experienced improved mortality rates when their doctors were at medical conferences (Harvard Medical School 2018). A possible conclusion could be that receiving less care was better for the patients. Some estimate that medical errors have been the third leading cause of death in America. Other than the patients, it is in no one’s best interest to do randomized trials, which is why they have been done for only 10 percent to 20 percent of the medical treatments used today.

There have been positive developments since Silver and Hyman’s book was published in 2018. Walmart and Amazon are now branching into healthcare, and other large corporations are considering the same. Mark Cuban’s CostPlus Drugs cuts out middlemen and makes transaction fees transparent. Progressive billionaire

John Arnold is funding nonprofit production of insulin. In an important article, Laffer, Van Horn, and Fisher (2022) show how private companies finally have options to begin controlling their healthcare costs. However, these changes have been in the private sector. Democratic commitment to nationalized control of healthcare requires a conservative/classical liberal response.

A conservative healthcare proposal should interact with and move beyond Silver and Hyman's critique and recommendations. Why do veterans have separate hospitals? We should instead provide veterans with health savings accounts (HSAs) and high-deductible insurance plans.

Medicaid should be adapted using federalist principles. Rather than nationally mandating changes in Medicaid, Congress should make them optional for states. We should not mandate insurance plans that cross state lines. Progressive states should be free to structure their insurance plans around community health centers, bundled payments, and preventive care. (Although the Centers for Medicare and Medicaid Services' attempt to turn community centers into voting registration centers reminds us of the inherent political dangers of this approach.)

States should have the option of providing individuals on Medicaid with HSAs and high deductible insurance plans. Current Medicaid plans are both expensive and ineffective. After Obamacare's passage, Oregon radically expanded Medicaid. Because it was unable to accept all who applied, Oregon created an outstanding test case. The conclusion? Those on Medicaid did not have better health outcomes than those who remained outside Medicaid (Silver and Hyman 2018, 286). It would be much better to change federal law, which currently prohibits Medicaid programs from offering HSAs, and let individuals run their own cost-benefit analyses and benefit from their choices. A more recent article by Silver and Hyman (2019) helpfully details some of the opportunities and challenges of this approach.

Obamacare preferentially subsidizes hospitals over non-hospitals. A doctor can recoup more money if his practice is bought by a hospital. The federal government thereby pays more for the same doctor performing the same surgery in the same building. As hospitals control more medical services, they can demand higher payments from insurers. Removing this preferential subsidy could limit hospitals' ability to charge monopoly prices. Hospital mergers also require closer analysis. Left or right, everyone hates monopolies.

The so-called Inflation Reduction Act gave Medicare the ability to determine prices for some drugs (Hopkins 2022). A better option is that suggested by Silver and Hyman. Perhaps controversially for some on the right, Congress should allow individuals and organizations to purchase drugs across national borders. (Some states already do this.) By allowing for an international drug market, Congress could lower American drug prices. Because companies could refuse to sell a drug in a country that regulates prices below appropriate compensation, America would not be outsourcing government price control to other countries. However,

American citizens would no longer subsidize European drug consumption, as is currently the case.

Moderates who are intrigued by the cross-border drug policy could find other ideas appealing. Medicare should be legislatively changed to allow purchasing via programs like Mark Cuban's CostPlus. Corporate health insurance write-offs should be capped to give individuals the same benefit. Individuals should be able to write off charges for cooperative medical programs like Medi-Share.

Congress should allow drug certification in Europe, Israel, and Canada to apply in the United States. The FDA could only deny the certification if it provided specific objections. Individuals should also be incentivized to practice medical tourism, both within the country and without. Laffer, Van Horn, and Fisher (2022, 12) tout the Surgery Center of Oklahoma, which publishes their relatively inexpensive surgery costs online (<https://surgerycenterok.com/pricing/>). University faculty members can especially appreciate this center's minimal administrative hiring, which lowers the cost of services.

Every time Congress has engaged in healthcare policy, it has spent more money. Silver and Hyman appropriately apply Groucho Marx's quote to politicians: "These are my principles. If you don't like them . . . well, I have others." With the demographic changes occurring in both political parties, perhaps upcoming elections will encourage more responsible governance. Progressives are correct in arguing that massive healthcare inefficiencies hurt our paychecks, proportionally harming those with lower incomes more than those with higher incomes. Those who are committed to Lincoln's "temple of liberty" must do the hard public policy work of resolving our national healthcare crisis. If they do not, ambitious progressives will be more than happy to oblige.

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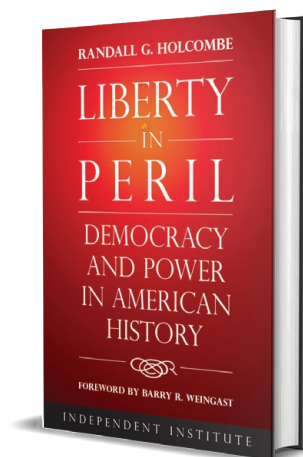
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