13

Numbered Days, Valued Lives: Statistics, Shopping, Pharmacy and the Commodification of People

Melanie Rock

On November 19, 1999, Allan Rock, Canada's health minister at the time, declared: "Diabetes costs the Canadian economy an estimated $9-billion per year, and may account for 5 to 14 percent of health care expenditures in Canada."[1] These words formed part of speech to inaugurate the Canadian Diabetes Strategy, an initiative whose stated goals are to monitor and minimize the impact of diabetes.[2] The dollars, in the billions, invoked by Minister Rock to convey the societal impact of diabetes do not disappear. Dollars change hands to cover hospital stays and pharmacological treatment, generating sales and expenditures in equal measures, but for different parties. In addition to such direct costs, diseases may involve indirect costs, such as "lost productivity," that is, potential wages and profits that never materialized. Costing the global impact of a disease, by suggesting ways to increase health and wealth, thus evokes an alternative present and a malleable future.

This chapter analyzes how knowledge about the effects of diabetes may help generate profit, loss, and, thereby, interest in the disease. Many corporations currently construe people with diabetes as a population replete with needs that may be met, at least in part, by exchanging dollars for goods and services. These needs are held to vary according to the sweetness of blood, "type" of diabetes[3] and the presence of "complications,"[4] as well as gender, age, and other characteristics (see Meltzer et al. 1998). Diabetes specialists exhort physicians to treat diabetes "aggressively" because clinical trial results suggest that continual monitoring and tight control over glucose levels will improve and extend lives.

The diabetic body is very much part of this calculus; but what is its status? I will argue that human bodies undergo commodification—yet without being bought, sold, or traded away—when estimating the benefits, costs, and profitability of health-related technologies and services. In the health arena and more generally in Canadian society, human life is often considered sacred, such that human bodies are viewed as valuable things to be preserved and nurtured—that is, kept alive and well.[5] Consistent with the notion that human lives have equal inherent value, a notion enshrined in the Canadian Charter of Rights and Freedoms (1982), human bodies are understood as valuable, malleable, and perishable things that require nurturing to sustain and enhance life. Since many different commodities may be used to sustain and enhance life, health status may engender widespread concern and many financial transactions.

In this light, the present chapter seeks to fuse insights from the anthropology of economic systems with the anthropology of medical systems and the cultural politics of embodiment. To analyze how the profit motive currently combines with health concerns, with the lively tissue and prospects of human existence, this chapter focuses on a particular line of business: the drugstore. More specifically, I investigate why, in the 1990s, Canada's largest drugstore chain construed diabetes as a marketing opportunity. The analysis encompasses the distribution and consumption of pharmaceuticals and other products designed to avert or treat disease, but I also draw attention to how the highly regulated sale of medications routinely intersects with trade in far less prestigious goods, including shampoo, bars of soap, and toilet paper.

This chapter aims to extend an active research agenda in anthropology that draws upon exchange theory to analyze various phenomena that biomedical research and related technologies have helped bring into existence (see, e.g., Hogle 2000; Layne 1999; Lock 2001; Scheper-Hughes 1996). Contributors to this anthropological research agenda have been concerned with the removal, preservation, transfer, and consumption of *body parts,* broadly conceived to include organs and tissues but also minute fragments, even single cells (Sharp 2000). Notably, especially in Western countries, laws and less formal codes regulate the circulation of human organs, tissue, and cells to approximate the ideal of social solidarity through giving, particularly altruistic giving rather than direct exchange (Mauss 1967; Parry and Bloch 1989; Titmuss 1971).

Anthropological research on organ transplants, in vitro fertilization, and other biomedical treatments that involve the removal of material from human bodies has highlighted variation within and across social arenas in the politics of giving, getting, and keeping. It has sometimes been implied that bodily fragmentation is the key concern with the politics of giving, getting, and keeping in biomedicine and related domains (see Sharp [2000]). This position suggests that, to the extent that a human body remains intact (that is, to the extent that people retain all of their "original parts," if not each and every cell with which they were born), persons have elided commodification.

In a bid to foster further reflection about the implications of such a position, the present paper presents and analyzes a case study in which human bodies undergo a form of commodification in a capitalist system permeated by biomedical technologies and notions, yet without physically undergoing fragmentation. Indeed, in this case study, profits are extracted by marshaling a veritably sacred value ascribed to intact ("healthy") human bodies. Keeping while giving, from the point of view of the people with diabetes who frequent these drugstores, means keeping body and soul together—partly by "giving up" some of their "free time" to shopping for medications and other things that research has shown will probably prolong their lives; keeping while giving, from the point of view of the pharmacists and the drugstore chain with which they are affiliated, means keeping valued customers—partly through "giving away" professional advice (cf. Godelier 1999; Miller 1998).

BACKGROUND TO THE CASE STUDY

Shoppers Drug Mart pharmacists fill approximately 17 percent of all prescriptions and sell about 13 percent of all over-the-counter medications across Canada. The chain operates under the Pharmaprix banner in Quebec in a bid to appeal to that province's francophone majority. A pharmacist, known as an "associate," owns and operates each store under a license agreement. In return for a share of the profits that varies by store, the chain oversees advertising, promotion, store fixtures, design, merchandising, and accounting. "The system combines entrepreneurial drive and close community ties with the benefits of national scale," according to a recent annual report (Bloom 1999).

During the twentieth century, pharmacists compounded fewer and fewer medicines as an international pharmaceutical industry gained strength. Nevertheless, "the growing complexity of drug therapy, the growth of public con-

cern about iatrogenic disorders, and the recognition that the public needs drug education and counselling has created new social roles for the pharmacist, especially in the area of hospital pharmacy" (Turner 1987:144). Below, I examine the promotion of these new roles for pharmacists in a drugstore chain—a strategy designed to retain the chain's most desired customers.

Pharmacists have a legal monopoly over dispensing an array of pharmaceutical products in many countries, but the "petty bourgeois image of retail pharmacy" has arguably constrained the status of this profession (Turner 1987:144). Presumably, this "general storekeeper" image has also deterred many sociologists and anthropologists from conducting research among pharmacists and on the pharmacy business. Several recent ethnographic studies and review articles by anthropologists scrutinize the manufacture, prescription, and consumption of pharmaceutical products, but not their distribution (see Clarke and Montini 1993; Nichter and Vuckovic 1994; van der Geest, Whyte, and Hardon 1996; Vuckovic 2000; Vuckovic and Nichter 1997). British sociologists have, however, recently revisited the professional status and role of the retail pharmacist; they have highlighted that the power to transform drugs into medicines is vested in pharmacists, and that retail pharmacists have actively sought to enhance their status by formalizing their involvement in the surveillance of prescription and nonprescription medicine sales (Dingwall and Wilson 1995; Harding and Taylor 1997; Hibbert, Bissell, and Ward 2002).

The retail pharmacy business did not figure in my original plans for research into scientific and public knowledge about diabetes. But over the course of field research focused on how, in the 1990s, diabetes gained greater recognition as a public health problem, drugstores became highly visible as sites where a dizzying array of insurance plans, pharmaceutical products, medical devices, and supplies articulate with people whose blood is dangerously sweet. These transactions interlace with the statistical "typing" of people (after Hacking 1986). Biomedical categories such as type 1 diabetes or type 2 diabetes establish certain people as in need of certain medications and supplies, helping to structure the flow of money. In turn, the statistical analysis of sales, profits, and losses helps structure merchandising, advertising, and promotions. Via such statistics, sweet blood gained recognition in the 1990s as an important "business line" in the Canadian drugstore business. Through marketing and promotion campaigns, in turn, drugstore chains contributed to a

renewed public understanding of sweet blood as an urgent problem that can be redressed in the here and now.

I first became aware of the role that pharmacists can play in managing diabetes, and fine-tuned awareness in drugstore chains of this role and its utility for marketing purposes, while in Ottawa, Canada's capital, conducting participant-observation research at the 1999 Canadian Diabetes Association Professional Conference. Each registrant received a backpack bearing Shoppers Drug Mart's Healthwatch® logo. When I visited the Shoppers booth in the exhibit hall, the representative on hand (whose title is "disease state manager") told me that the next Diabetes Clinic Day would feature results from a landmark type 2 diabetes clinical trial, namely, that tight blood pressure control as well as tight glucose control can reduce complications and extend lives (see United Kingdom Prospective Diabetes Study Group 1998a, b, c.)

To learn more about how and why Shoppers Drug Mart's head office seized upon diabetes as a marketing opportunity,[6] I later conducted a formal extended interview at company headquarters in Toronto with the disease state manager whom I met at the 1999 Canadian Diabetes Association Professional Conference, and I integrated questions about the pharmacy business into more than twenty-five interviews with leading diabetes researchers, clinicians, registered diabetes educators, product representatives, and bureaucrats. I also analyzed more than one hundred company documents, three hundred newspaper articles, one hundred hours' worth of verbatim speeches by politicians and diabetes researchers, the authorized biography of Shoppers Drug Mart's founder (see Rasky 1988), and scores of government documents, independent market research reports, and magazines. I did not, in other words, study a sample of pharmacists in detail. Rather, I investigated the incorporation of public polices along with epidemiologic and demographic data in retail pharmacy management and then analyzed the results of this investigation through the lens of theory in economic anthropology.

PUTTING A DOLLAR VALUE ON HUMAN NEEDS

A taboo on expressing the value of human lives directly in dollars has fueled reliance on a plethora of "end points" and "quality of life" instruments to measure and compare health status in populations (Epstein 1997; Koch 2000; Löwy 2000; Porter 1992; Rock 2000 for discussion). Human life, from this perspective, is sacred and hence should be valued apart from money. Yet mone-

tary flows have been associated with the length and overall quality of human lives. In anthropological terms, the practice of expressing quality of life in relation to dollars, as opposed to in dollars, signals the existence of distinct regimes of value (after Appadurai 1986; Bohannan 1959; Kopytoff 1986).

Anthropologists have historically contrasted commodity with gift exchange in ways that reflect the tendency, since the abolition of slavery in Western countries, to separate monetary value from the value accorded human beings (Bloch and Parry 1989; Miller 1995; Strathern 1996). This distinction—that is, what money can or ought to buy, versus what gifts can or should bring—has infused the political economy tradition and anthropologists' contributions to this tradition. A synthesis of the Marxist understanding of the commodity and the Maussian understanding of gifts that has proved influential in anthropology (see Gregory 1982 and table 13.1) suggests that gifts have an animate character usually not found in commodities. From this perspective, gifts involve and cement personal relationships, while the exchange of commodities remains impersonal. Yet social rank may interweave with commodity consumption: the conversion of commodities into gifts provides a key case in point (Gregory 1982:167–209; see also Miller 1995; Yang 2000). For Gregory, however, commodity exchange—laid bare—comprises a series of vapid transactions that, in the aggregate, set groups of people apart from one another.

Thomas argues that Gregory's distillation of how commodities differ from gifts to exchange revolves around ideal types, which blur in practice: "Precisely because the theoretical contrast is developed with such clarity, the question arises of whether the postulated gift is anything other than the inversion of the commodity" (Thomas 1991:15). This question, in turn, supposes that anthropologists fully grasp the nature of commodification—at least in "the West." Thomas observes that "commonsensical practical knowledge" dictates that, for example, "one does not go into a shop to establish or consolidate a social relationship" (Thomas 1991:8). Yet the case study of interest in this chapter involves

Table 13.1 Gifts vs. Commodities

Commodities	*Gifts*
Alienable	Inalienable
Quantity (Price)	Quality (Rank)
Objects	Subjects

(Thomas 1991, 15; after Gregory 1982)

a network of pharmacist-shopkeepers seeking to establish and consolidate a relationship with certain customers possessed of sweet blood.

I do not defend a particular definition of the commodity, nor of the gift, in this chapter. Therefore, I do not engage some recent empirical research and theorizing on the relationship between gift and commodity exchange in Western and non-Western contexts (e.g., Carrier 1997; Gell 1992; Goddard 2000). Instead, the case study analyzed in this paper suggests that the salience of the commodity/gift distinction in economic anthropology, in Western societies and in many non-Western societies, has led anthropologists to identify—readily and quite accurately—*certain* biomedical practices, ones that fragment human bodies, as economic and political phenomena; yet anthropologists have so far not applied theories from economic anthropology to analyze biomedical renderings of human bodies that do not involve the transfer of body parts or physical dismemberment. To help demonstrate the pertinence of theory from economic anthropology for understanding the deployment of biomedical knowledge to keep human bodies alive and intact for as long as possible, I analyze how a particular company capitalized on some of the qualities that have, in the anthropological literature and more generally in Western societies, been associated with gift exchange. Put simply, Shoppers Drug Mart sought to imbue the monetary exchange for goods such as medicines, medical technologies, and medical supplies with traits often associated with gifts.

The point of departure for this chapter is the analysis of value setting, as opposed to the commodity/gift distinction. Here I follow Appadurai (1986), who has argued convincingly that owing to the emphasis on the commodity/gift distinction in economic anthropology, certain processes that are common to all transactions have escaped attention. He observes, however, that even conceptualizing something as exchangeable entails value setting. He refuses to define "the gift" or "the commodity" and instead offers a definition of a "commodity situation": the situation in which a thing's exchangeability—past, present, or future—for some other thing is a socially relevant feature (Appadurai 1986:13). While Appadurai confines his analysis to the commodification of things, as opposed to people (cf. Kopytoff 1986; Strathern 1992), his insights helped me see that the statistical "typing" of bodies in biomedicine stems from valuing human life in, simultaneously, categorical and qualified terms. Paradoxically, the sacred value assigned to

human life leads to differentiating among people on the basis of statistics that index the length and overall quality of their lives. Viewed biostatistically, some people seem better off because they are kept alive longer and in better condition.

Putting aside conventional understandings of commodities and gifts in light of Appadurai's (1986) focus on the politics of need and desire, it is clear that the statistical typing of people construes human bodies as malleable, valuable, and interchangeable things. Yet each human body is also unique, particularly from the perspective of the person contained therein (after Kopytoff 1986). This tension between commonality and singularity defies resolution. Nevertheless, the notion that human beings are simultaneously fungible (as members of populations) and idiosyncratic (as individual persons) often seems unremarkable.

That human bodies replace themselves over time, changing as they age, underpins the possibility of shopping for ways to extend and improve on the sacred "gift of life" (cf. Layne 1999). The pharmacy has become a site where Canadians actively weigh the costs and benefits—financial and otherwise—of intensively monitoring and controlling the sweetness of their blood, among many other ominous signs and symptoms. Shoppers Drug Mart has succeeded in charging associations between monetary expenditure and lifeblood to its advantage, which has entailed carefully minimizing any appearance of mercantilism. That is, the company has tried to avoid any suggestion that while Shoppers Drug Mart benefits from diabetes, people with diabetes do not benefit from Shoppers Drug Mart.

HEALTH INSURANCE IN CANADA

Before we proceed further, a few words on the structure of Canada's health care system are in order. Commentators often mistake Canada's health care system for a "socialized" system. In fact, most physicians in Canada are in private practice. Their income depends on the number and type of services that they provide. While most physicians in Canada are in private practice, publicly funded health insurance covers all Canadians. The federal government transfers funds to Canada's ten provinces to cover a portion of the costs entailed in delivering health care in clinics and in hospitals, provided that provincial health insurance plans embody five principles: public administration, comprehensiveness, universality, portability, and accessibility.

Provincial health insurance plans in Canada cover all products consumed and services rendered within hospitals, but these plans vary widely in the extent to which they cover pharmaceutical products and medical supplies prescribed for consumption off hospital grounds. Many, but by no means all, Canadians receive coverage for a select range of pharmaceuticals, medical supplies, and services such as dentistry, massage therapy, or counseling through private insurance, typically offered as part of an employee benefits package.

The issue of insurance coverage for pharmaceuticals and the price of these products recurs in charged debates about the future of Canada's health care system, as illustrated by two articles published in the *Globe and Mail,* a nationally circulated newspaper, on consecutive days in 2001. "Six Million Lack Proper Drug Plans, Study Finds," read the headline of the first of these articles (Picard 2001a). The headline of an article published the very next day read, "Spending on Drugs Up, Data Say" (Picard 2001b).

For people with diabetes and organizations such as the Canadian Diabetes Association, the cumulative, lifelong financial impact of sickly sweet blood and the availability of insurance coverage to offset these costs are of concern. The capacity to meet diabetes-related needs and the impact of these needs on household budgets vary across Canada with employment status, province of residence, income, and insurance coverage. On average, the Canadian Diabetes Association estimates that someone with diabetes incurs medical costs that are two to five times higher than those of a person without diabetes. Each time people with diabetes test their own blood sugar, which they are advised to do several times a day, the necessary supplies cost about a dollar. In an interview published in the Canadian Diabetes Association's magazine targeting adults with diabetes, the then newly appointed public policy and government relations director, Debra Lynkowski, named as the three most pressing issues in her portfolio government awareness of "the huge financial, emotional and social costs related to diabetes," "full access to reasonable and adequate insurance coverage," and the "drug review process and pricing" (see *Diabetes Dialogue* 1999).

TARGETING SWEET DEMOGRAPHICS

People do not have to be bought or sold outright for human bodies, in whole or in part, to undergo commodification. Wage labor, for example, commodifies time spent in human bodies while also accommodating a taboo on buy-

ing and selling persons. Moreover, entire human populations undergo commodification when the individual bodies comprising them are construed as amenable to improvement, that is, when it seems possible and even imperative to exchange one sort of future for another through the allocation of resources, here and now (Rock 2000; cf. Sharp 2000). Below, I aim to contribute to knowledge about how human bodies may constitute repositories of value under capitalism by simply existing or, more specifically, by exhibiting recognized needs and the potential for meeting these needs.[7] The analysis trains attention on how biomedical knowledge about diabetes interlaces with the evaluation of the productivity and profitability of consumption, with particular concern for bodily action *not* bought and sold as wage labor.

The human body's conversion of food into glucose does not count as labor but underlies the capacity to labor. Two known "modifiable risk factors" for type 2 diabetes, which accounts for 90 percent of all cases, are high body mass and infrequent physical exertion (Black 2002)—both intimately related to "lifestyle," to the patterning of production and consumption. People with all types of diabetes, whose cells cannot absorb glucose from the bloodstream, have dangerously sweet blood. Primary prevention of type 2 diabetes (averting the onset of individual cases) and secondary prevention (averting the onset of complications in individual cases through timely diagnosis and aggressive treatment) promise to extend the capacity to labor in the course of extending lives. Statistics incorporating lost productivity are often bandied about in rhetoric about diabetes, as illustrated by the speech cited at the outset of this chapter. Yet in Canada, the possibility of extending and enhancing "life itself" (cf. Foucault 1994; Franklin 2000) receives discursive emphasis,[8] along with the concomitant potential to reduce personal and public health care expenditures (Rock 2003a).

During the 1990s, Shoppers Drug Mart's stress on the pharmacist as a health professional emerged and evolved, reinforcing and exploiting public concern about health, health care, and health care expenditures. The company's current focus on diabetes and other select health concerns also entwines with innovations in information technology, the franchise structure of the company, demographic trends, public policies, pressure exerted by competitors, and access to large amounts of capital.

Testifying to the success of Shoppers' emphasis on health and professional service, in 1999, a self-described "once-sleepy wholesaler" aired a series of television

spots specifically designed to wrest away from Shoppers the "moral high ground" (Brent 1999). The advertisements dramatized true stories involving pharmacists supplied by the wholesaler going above and beyond the call of duty. One spot featured a pharmacist climbing over rock slides to deliver medication to a hospital; another featured a pharmacist awakened by an emergency call, opening her store in the dead of night, and delivering supplies to a maternity ward.

But how did Shoppers Drug Mart, a drugstore chain steeped in tobacco profits, manage to gain Canadian pharmacy's "moral high ground"? Imperial Tobaccos was the flagship of Imasco, the conglomerate that owned Shoppers Drug Mart from 1978 until it was dismantled in 1999. In turn, Imperial Tobacco is and was part of the British American Tobacco (BAT) group, whose U.S. subsidiary, Brown and Williamson, plays villain in the film *The Insider.*[9]

In 1992, Shoppers began distributing fact sheets about each new prescription, billed as Healthwatch® Reminders (Bloom 1995). These PILs, for "patient information leaflets," are hardly unique to Shoppers Drug Mart, yet they have helped Shoppers Drug Mart build brand-name recognition for its pharmacy services under the Healthwatch® banner (Ralston 2000). With the computerization of prescription claims, pharmacists are positioned to detect potentially harmful drug interactions, as well as efforts to fill the same prescription more than once. Today Shoppers Drug Mart trumpets the health advantages for consumers gained by computerization as part of a comprehensive Healthwatch® System. Yet to a significant extent, Healthwatch© System components other than PILs owe their existence to Wal-Mart.

In 1994, the American discount chain Wal-Mart entered Canada, courtesy of the 1988 Canada-U.S. Free Trade Agreement, with the purchase of more than 120 stores. Wal-Mart pharmacists currently dispense approximately 5 percent of all prescriptions in Canada. The chain offers low prices on pharmacy products to lure customers. Following Wal-Mart's entry into the Canadian market, other large-surface stores installed pharmacy departments; and, like Wal-Mart, they began using prescription and over-the-counter drugs as loss leaders. These new players slashed dispensing fees, the fees levied by pharmacists on each prescription drug order that they process. A discount mail-order prescription business also set up shop (Greenwood 1993). Presented with the possibility of obtaining the same prescription drugs for less from new players, consumers took increased notice of dispensing fees, as did third-party insurers, both public and private.

These dynamics played out in the Ontario government's adoption, in 1996, of a policy to contain pharmaceutical spending under its health insurance plan. Since July 15, 1996, senior citizens and welfare recipients in Ontario pay CAN$2 to fill each prescription, whereas the provincial government used to cover fully their dispensing fees. In response, Wal-Mart promised to absorb each CAN$2 levy. It also slashed its dispensing fees to CAN$4.11; Shoppers Drug Mart and other chain drug stores were charging about three times as much to process prescriptions (Brent 1996a).

"Some retailers will elect to use pharmacy as a traffic builder and treat prescriptions as a commodity to sell more food or soft goods," observed Shoppers' CEO David Bloom at the time (cited in Brent 1996b). But Shoppers also prized health-related purchases for their capacity to draw customers into their stores, necessary to trigger all-important impulse buys. On the day that Ontario's new policy took effect, Shoppers rolled out a new program for Ontario seniors—but not for welfare recipients. Dubbed the Healthwatch® Seniors Club, the program offers a 10 percent discount on its private-label stock, including vitamins, over-the-counter medications, and medical supplies (Brent 1996b).

Wal-Mart, meanwhile, took square aim at employer-sponsored health insurance plans. In exchange for exclusivity, it offered "monitoring and counselling services to ensure maximum cost containment and efficient administration of prescription drug programs" (Brent 1996a). A consultant interviewed for the story noted: "It locks in a whole bunch of people that are affiliated with the partner, and it starts getting the message out that this is the lowest price." He expressed surprise that Shoppers Drug Mart had not adopted this "clever strategy" (cited in Brent 1996a).

In response to fierce new competition, Shoppers reexamined its operations. In 1994, market research among its pharmacists revealed that four medical conditions—diabetes, cardiovascular disease, asthma, and arthritis—generated more regular visits to Shoppers Drug Mart locations than any others did. Of these four diseases, managers at Shoppers Drug Mart's central office decided to focus initially on diabetes, partly because of established links with the Juvenile Diabetes Foundation,[10] but also because of its profitability.

Diabetes-related merchandise was identified as a significant "shopfront" category, meaning inventory besides prescription drugs, mainly owing to the profit margins on equipment and supplies to monitor blood glucose levels.

Shopfront sales had taken on renewed importance in the 1990s with new competitors offering lower dispensing fees on prescriptions and with the reclassification of many prescription drugs to over-the-counter status as provincial governments sought to reduce health care costs. Over-the-counter drugs are not reimbursed under prescription drug plans, which can discourage their purchase, noted Shoppers' CEO in an annual report to Imasco shareholders (see Bloom 1995).

In September 1994, the Shoppers chain hosted a trade show for its Toronto-area pharmacists, which featured "newfangled" blood glucose monitors designed for patient use.[11] This trade show led Shoppers Drug Mart pharmacists to reflect on how blood glucose monitors and supplies available for purchase in their stores, as well as pharmaceuticals, stand to affect health outcomes. Participants rated the experience highly. In 1995, the company created a new head-office position, the disease state manager, who promptly organized workshops modeled on the Toronto event in locations across Canada.

In 1996, Shoppers Drug Mart intensified the focus on pharmacists' role in diabetes management, with a view to positioning them as active and vital members of the diabetes health care team. Shoppers' disease state manager prepared a resource manual to enhance pharmacists' understanding of diabetes and their role in its control. The company also printed logbooks for distribution to customers, which proved very popular. It turned out that although people with diabetes are supposed to self-monitor the sweetness of their blood at regular intervals, they lacked a ready, steady supply of logbooks in which to record and track their routine blood glucose tests.

In 1998, the "Healthwatch® Diabetes Care Tool Kit" entered a new phase, and the first annual Diabetes Clinic Day took place. By then, Shoppers Drug Mart had developed planning tools and held a "clinic day" to promote better use of asthma medications. "This was the pharmacist coming down from the upper echelon," said the Shoppers Drug Mart disease state manager when reflecting on this event in an interview with me. The "asthma experience" served as a prototype in designating a Canada-wide diabetes clinic day and developing a plan to help guide and reinforce diabetes counseling by Shoppers Drug Mart pharmacists. The diabetes plan incorporates prompts to related information sheets on hypoglycemia, healthy eating, and blood glucose monitoring. Each pharmacist also received a two-sided, laminated card to assist in matching different kinds of customers with blood glucose monitors. Here

types of diabetes join stock demographic variables, health insurance coverage, personality, computer skills, "cost consciousness," and the presence of certain physical limitations (such as reduced dexterity and vision impairment) as considerations in the purchase of equipment to monitor the sweetness of blood. In partnership with the Canadian Diabetes Association, Shoppers Drug Mart also developed and distributed a quiz, under the banner "Are you at risk?" to reach customers who had not been diagnosed with diabetes.

Legislation governing health professionals prevents pharmacists from drawing blood. "What could we do without finger pricking that would be of value?" Shoppers Drug Mart central office staff asked. The emphasis on information in the Diabetes Clinic Day emerged in response. The "value-added" component would be knowledge about one's own health, symbolized by a number that situated the individual in a large population. The number would help, and hopefully satisfy, individuals wanting to know, "How do I rate?"

Shoppers' head office has sought to impress upon its pharmacists that many people with diabetes remain underinformed about the disease, to the point that about a third of all people with type 2 diabetes do not even know that they have this condition (see Harris et al. 1997). By providing educational services in their stores, including appropriate referrals, Shoppers Drug Mart stresses that the pharmacist may positively affect patient outcomes.

To promote commitment among its pharmacists to the prevention of diabetes and its complications, Shoppers Drug Mart publishes a newsletter, *Diabetes and the Pharmacist,* under the Healthwatch® banner. By way of illustration of its contents, the May 1999 version contained information about the Juvenile Diabetes Foundation "Walk for the Cure" fund-raiser; told readers that thirty-nine more of its pharmacists had elected to write the Diabetes Educator Certification Exam under the auspices of the Canadian Diabetes Association; provided information about two clinical trials seeking subjects that "you may wish to tell your patients about"; listed specials on diabetes-related shopfront merchandise that were slated for inclusion in upcoming issues of the national flyer; introduced Regenex®, the recombinant DNA gel that aids the healing of diabetic foot ulcers; highlighted target glucose and lipid levels set out in the *1998 Clinical Practice Guidelines for the Treatment of Diabetes in Canada;* featured a common "patient question" about the use of herbs to control the sweetness of blood, to which a pharmacist with a Ph.D. gave a pagelong reply; and, finally, presented evaluation results from the latest Diabetes Clinic Day.

Faced with Wal-Mart and other new competitors, Shoppers Drug Mart wanted to persuade customers to continue doing business with it and individuals and insurers to pay premium prescription dispensing fees for the privilege. The company responded by promoting concern for the health of its customers. Cultivation of the pharmacist-customer relationship took place alongside a very substantial reorganization of the Shoppers Drug Mart network. Until 1997, Shoppers pharmacist-associates did all their own buying from individual vendors and kept their own books. Since 1997, Shoppers Drug Mart has maintained a central accounting system and database, point-of-sale systems, and regional distribution centers linked by satellite to individual stores (Brandao 1997:129) Imasco annual reports from the mid-1990s stress that, in return for the CAN$250-million outlay to realize these changes, billed internally as Vision 97, shareholders could expect greater market share and profitability. Diabetes counseling, which these changes promised to enhance, appeared as a flagship for customer loyalty in Imasco's 1995 annual report:

> In 1995 Shoppers expanded our pharmacists' advisory role by inaugurating a counselling program aimed at patients with chronic diseases. The first disease targeted was diabetes and a system-wide training program enhanced our capacity to help diabetic patients monitor and achieve better control of their blood sugar levels. Private counselling is the fastest growing service area in pharmacy, and Shoppers' health-care advisory function will soon expand to include other diseases such as cardiovascular disease, asthma, and arthritis. This amplified role will be stepped up as Vision 97's streamlining measures free our pharmacists to spend more time with customers. (Bloom 1996:15)

In the end, Shoppers Drug Mart elected to develop a program focused on women's health rather than on arthritis because women of all ages form such a significant portion of the company's customer base: they tend to shop for themselves and for family members. Moreover, the three other main traffic-generating medical conditions—asthma, diabetes, and cardiovascular disease—are all potentially fatal, underscoring the importance of sound management (Ralston 2000).

The establishment of diabetes and other "disease state" management programs from 1996 onward extended and built recognition for the Healthwatch® brand:

> By focusing on specific disease states such as diabetes, asthma or heart disease, and by fostering a strong connection to Shoppers Drug Mart, we built trust across the board—and not just from people suffering from these diseases. Now we could be seen as managers of health outcomes, reflecting the consumer trend towards self-care. (Ralston 2000)

While the company has historically spent a large part of its advertising budget on television spots, it currently promotes the Healthwatch® brand in magazines as well. For example, it advertises in *Diabetes Dialogue,* the Canadian Diabetes Association's publication for adults, as well as in mainstream magazines. According to a spokesperson, "Healthwatch advertising shows a commitment to pharmacy, thereby increasing its value to the consumer. It has allowed Shoppers to develop a pharmacy brand—an industry first" (Ralston 2000).

Thus, by the mid-1990s, Shoppers Drug Mart aimed to deploy its pharmacists as the vanguard of customer service. Relieved of the minutiae of merchandising and accounting, the pharmacist would be "free" to concentrate on providing services of professional caliber. In doing so, the local pharmacy would embody a "health destination," and while in the stores, customers could attend to other needs as well as impulses. The company and its advertising agency focused on "sweet demographics": people with diabetes and other chronic conditions that generate frequent pharmacy visits, with particular regard for those with higher incomes and insurance for prescriptions.

Annual reports from the late 1990s and 2000 portrayed this renewed focus on professionalism and desirable demographics as a source of competitive advantage. Total sales grew from CAN$3.3 billion in 1995 to CAN$4.3 billion in 1999; total earnings increased from CAN$101 million in 1995 to CAN$277 million in 1999.[12] By 1999, prescriptions, over-the-counter medications, and medical supplies together accounted for 55 percent of total sales. "Nutraceuticals"—vitamins, minerals, herbal remedies, and other dietary supplements—had become more significant and increasingly occupy a demarcated area near the dispensary. After the company installed such kiosks, vitamin sales increased 40 percent (Hanson 1999). A renovation program currently under way aims to facilitate "patient-pharmacist dialogue" and improve the "customer's shopping experience" by introducing waiting areas near dispensaries, semiprivate counseling areas, and private consultation rooms, among other reforms (Bloom 1999:14). Rather than slashing dispensing fees, explained Shoppers'

CEO to investors, "Shoppers Drug Mart's approach is to demonstrate to payers that pharmacy services, properly managed, lead to better patient outcomes and lower overall health-care costs" (Bloom 1999:13). To date, the company has not released any evidence that its approach has led to better outcomes for customers with diabetes or other chronic medical conditions, but by referencing health in advertising, in-store promotions, and pharmacist services, Shoppers Drug Mart certainly has managed to reposition itself most profitably in an altered marketplace.

CONCLUSION

In the late 1980s, some predicted that by the year 2000, pharmacists would become health advisers, such that "you'll have to make an appointment and pay a fee for the consultation as you would with a physician" (Rasky 1988:325). In fact, Shoppers Drug Mart and certain competitors have "freed up" pharmacists to "give away" consultation services on the spot and by appointment, the better to attract and retain choice customers. The development and promotion of "free" Healthwatch® services, such as diabetes education, also help justify the annual franchise fee levied on associate pharmacists. Retail pharmacists receive billing as health professionals, free to "share" their expertise with customers who value their help. The trick of the Healthwatch® brand and related services has been to coat expenditures on disease management and prevention in a reassuring package, one that yields repeat business and a high profit-to-visit ratio.

When I sketched how Shoppers Drug Mart had embraced diabetes education, one interlocutor said, "They [people with diabetes] are cash cows." English-speaking Canadians may not like to imagine themselves as commodifying people, and we do not, at least in the vernacular, talk of human bodies as piggy banks or storehouses (cf. Strathern 1996:517), but we routinely conceive of certain people as "cash cows."

The notion that we might so value human life that health care and health promotion could command, rather than compete for, money and other resources has a romantic ring. Yet if commodification is a universal human phenomenon, the commodification of people would appear inevitable. The commodification of people does not mean that human bodies and body parts always circulate as "commodities" or "gifts," I hasten to add, but rather that they constantly undergo valuation and seem, to varying degrees, replaceable,

reproducible, desirable, and amenable to improvement (after Kopytoff 1986; Strathern 1996).

As customers become statistically typed in finer and finer terms (smoker? type 2 diabetic? Internet user?), terms that imbricate different people with products, and thus actual and potential profits, retailers and manufacturers truly understand people simultaneously—and interchangeably—as individuals and as populations (pace Foucault 1991). Even though detachment is theoretically characteristic of commodity exchange, the statistical trace left behind by each in-store transaction means that customers and their purchases remain symbolically attached from the company's point of view. Meanwhile, from the customer's point of view, the valorization of professional status and the power vested in pharmacists to convert mere substance into medicines mean that pharmacists and what they sell may also remain symbolically attached.

In the databases currently maintained by drugstore chains, biomedical categories mingle with postal codes, annual incomes, insurance plans, birth dates, and popular perfumes. A recent feature article on the business implications of point-of-sale technologies observed:

> Once upon a time, the person behind the counter knew virtually everything about everybody who walked into the shop. And that's really what today's technology and information gathering is leading up to: a return to one-to-one customer intimacy. (Menzies 2001)

Yet the intimacy achieved through point-of-sale technologies implicates distant statistical analysis, "data mining," rather than direct observation or face-to-face dialogues.

Shoppers Drug Mart's statistically mediated embrace of diabetes underscores that valuation and classification always entail some form of social mediation. The carapace of impersonality afforded by statistics (Porter 1992) permits the valuation of human beings and their lives to occur, for instance, in the guise of "merely" counting cases of diabetes or blood glucose monitors. This form of double counting, weighing the worth of people alongside the cost of supplies, is not necessarily sinister or disadvantageous to those evaluated, but it does take place. The condemnation of commodifying human bodies and body parts within anthropology and more broadly (see Sharp 2000)

would appear to conflate commodification (setting value, attributing exchangeability or interchangeability) with inequality. The commodification of people may be inevitable in human societies, but not so the form, conceptualization, and degree of inequality.

NOTES

A doctoral fellowship from the Social Sciences and Humanities Research Council of Canada made this research possible. The Université de Montréal's Groupe de recherche interdisciplinaire en santé awarded a travel grant for me to attend the 2001 Society for Economic Anthropology conference. I was able to revise this material for presentation and publication thanks to support in the form of a postdoctoral fellowship, sponsored by the Canadian Foundation for Health Services Research and the Canadian Institutes for Health Research and held at the Université de Montréal.

1. I share my last name with Allan Rock, but I do not know him personally. Several government officials, researchers, and representatives of lobbying groups asked me, during the course of my field research, whether I am related to this politician—serving notice of just how important personal contacts remain in Canadian politics.

2. These financial estimates were based on dividing counterpart U.S. figures by ten as the American population is approximately ten times larger than Canada's population; homegrown Canadian data of this nature were not available—one of the shortcomings that the Canadian Diabetes Strategy promised to correct.

3. All types of diabetes are diagnosed on the basis of the sweetness of blood (that is, elevated blood glucose levels).

4. People with diabetes are prone to a wide range of health problems including renal failure, erectile dysfunction, cavities, and gangrene. Compared to people without diabetes, they tend to die at a younger age, notably from cardiovascular disease. For further discussion of the politics of describing and ascribing "risk" in relation to diabetes, see

5. Notably, the death penalty does not exist in Canada.

6. This chapter's concern with how the head office of a drugstore chain identified a particular disease as a marketing opportunity complements research on the identification of disease as a market opportunity in the biotechnology sector (see Fleising 2001).

7. See Povinelli (1993, 2000) for a similar line of inquiry but a different problematics.

8. Field research suggests that employers evince concern not only about diabetics' capacity to labor but also about the "burden" placed by diabetes on employee benefit plans. These issues are not, however, openly discussed. They merit additional research.

9. The 1999 film *The Insider* was based on an investigative report (see Brenner 1996). For further information about Brown and Williamson, Imperial Tobacco, and BAT, see Cunningham 1996 and Glantz 1996.

10. In partnership with the Juvenile Diabetes Foundation of Canada, Shoppers Drug Mart has raised funds for diabetes research since the mid-1980s. A board member suggested that corporate donations focus on this charity after his son developed type 1 diabetes.

11. In the wake of clinical trials that found that intensive control over the sweetness of blood improves future prospects, the technological capacity to self-monitor blood glucose greatly increased.

12. The second-largest drugstore chain in Canada, the Jean Coutu group, also reported record earnings during this period.

REFERENCES

Appadurai, Arjun. 1986. Introduction: Commodities and the Politics of Value. In *The Social Life of Things: Commodities in Cultural Perspective.* Arjun Appadurai, ed. Pp. 3–63. Cambridge: Cambridge University Press.

Black, Sandra A. 2002. Diabetes, Diversity, and Disparity: What Do We Do with the Evidence? *American Journal of Public Health* 92(4):543–548.

Bloch, Maurice, and Jonathan Parry. 1989. Introduction: Money and the Morality of Exchange. In *Money and the Morality of Exchange.* Jonathan Parry and Maurice Bloch, eds. Pp. 1–32. Cambridge: Cambridge University Press.

Bloom, David 1995 Shoppers Drug Mart / Pharmaprix. In *1994 Imasco Annual Report.* Pp. 16–17. Montreal: Imasco.

———. 1996. Shoppers Drug Mart / Pharmaprix. In *1995 Imasco Annual Report.* Pp. 16–17. Montreal: Imasco.

———. 1999. Shoppers Drug Mart / Pharmaprix. In *1998 Imasco Annual Report.* Pp. 16–17. Montreal: Imasco.

Bohannan, Paul. 1959. The Impact of Money on an African Subsistence Economy. *Journal of Economic History* 19:491–503.

Brandao, Cristina P. 1997. Winning the Tech Wars: The Winners of This Year's Canadian Information Productivity Awards. In *Canadian Business* 70(28):129–130.

Brent, Paul. 1996a. Discounter Wal-Mart Targets Corporate Prescription Plans. In *The Financial Post.* May 3:7.

———. 1996b. Shoppers Fights Back against Price-Cutters. In *The Financial Post.* July 12:12.

———. 1999. "Once-sleepy" Drug Trading Runs Major Campaign: First Big Push in Ten years. In *National Post.* August 23:C04.

Canada. 1982. Canadian Charter of Rights and Freedoms. Ottawa, Ont..

Carrier, James G. 1997. *Gifts and Commodities: Exchange and Western Capitalism since 1700.* London: Routledge.

Clarke, Adele, and Theresa Montini. 1993. The Many Faces of RU486: Tales of Situated Knowledges and Technological Contestations. 18(1):42–78.

Dingwall, R., and E. Wilson. 1995. Is Pharmacy Really an "Incomplete Profession"? *Perspectives on Social Problems* 7:111–128.

Epstein, Steve. 1997. Activism, Drug Regulation, and the Politics of Therapeutic Evaluation in the AIDS era: A Case Study of ddC and the "'Surrogate Markers" Debate. *Social Studies of Science* 27(5):691–726.

Fleising, Usher. 2001. In Search of Genohype: A Content Analysis of Biotechnology Company Documents. *New Genetics and Society* 20(1):239–254.

Foucault, Michel 1991 [1978] Governmentality. In *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault.* G. Burchell, C. Gordon, and P. Miller, eds. Pp. 87–104. Chicago: University of Chicago Press.

———. 1994 [1979]. Naissance de la biopolitique. *In* Dits et écrits, vol. 3 (1976–1979). D. Defert, F. Ewald, and J. Lagrange, eds. Pp. 818–825. Paris: Gallimard.

Franklin, Sarah. 2000. Life Itself: Global Nature and the Genetic Imaginary. Department of Sociology, Lancaster University. Electronic document, www.comp.lancs.ac.uk/sociology/ soc048sf.html, accessed March 2003.

Gell, Alfred. 1992. Inter-Tribal Commodity Barter and Reproductive Gift-Exchange in Old Melanesia. In *Barter, Exchange, and Value: An Anthropological Approach.*

C. Humphrey and S. Hugh-Jones, eds. Pp. 142–168. Cambridge: Cambridge University Press.

Goddard, Michael. 2000. Of Cabbages and Kin: The Value of an Analytic Distinction between Gifts and Commodities. *Critique of Anthropology* 20(2):137–151.

Godelier, Maurice. 1999 [1996]. *The Enigma of the Gift.* Nora Scott, trans. Chicago: University of Chicago Press.

Greenwood, John. 1993. A New Deal on Drugs: Meditrust, Norman Paul's New Drug Mail-Order Business, Is a Bitter Pill to Swallow for Canada's Pharmacy Retailing Giants. In *The Financial Post Magazine.* Pp. 112.

Gregory, Christopher. 1982. *Gifts and Commodities.* London: Academic Press.

Hacking, Ian. 1986. Making Up People. In *Reconstructing Individualism: Autonomy, Individuality, and the Self in Western Thought.* H. C. Heller, M. Sosna, and D. E. Wellbery, eds. Pp. 222–236. Stanford, Calif.: Stanford University Press.

Hanson, Kim. 1999. Natural Remedies Boom: There May Be No Scientific Proof Herbal Remedies Work, but That Hasn't Stopped Family-Run Nutrition House from Building A 60-Store Business. In *National Post.* July17:D5.

Harding, G., and K. Taylor. 1997. Responding to Change: The Case of Community Pharmacy in Great Britain. *Sociology of Health & Illness* 19:547–560.

Harris, M. I., R. C. Eastman, C. C. Cowie, K. M. Flegal, and M. S. Eberhardt. 1997. Comparison of Diabetes Diagnostic Categories in the U.S. Population According to the 1997 American Diabetes Association and 1980–1985 World Health Organization Diagnostic Criteria. *Diabetes Care* 20(12):1859–1862.

Hibbert, Derek, Paul Bissel, and Paul R. Ward. 2002. Consumerism and Professional Work in the Pharmacy. *Sociology of Health and Illness* 24(1):46–65.

Hogle, Linda. 2000. *Recovering the Nation's Body: Cultural Memory, Medicine, and the Politics of Redemption.* New Brunswick, N.J.: Rutgers University Press.

Koch, Tom. 2000. Life Quality vs the "Quality of Life": Assumptions Underlying Prospective Quality of Life Instruments in Health Care Planning. *Social Science and Medicine* 51(3):419–427.

Kopytoff, Igor. 1986. The Cultural Biography of Things: Commoditization as Process. In *The Social Life of Things: Commodities in Cultural Perspective.* Arjun Appadurai, ed. Pp. 64–91. Cambridge: Cambridge University Press.

Layne, Linda, ed. 1999. *Transformative Motherhood: On Giving and Getting in a Consumer Culture.* New York: New York University Press.

Lock, Margaret. 2001. *Twice Dead: Organ Transplants and the Reinvention of Death.* Berkeley and Los Angeles: University of California Press.

Löwy, Ilana. 2000. Trustworthy Knowledge and Desperate Patients: Clinical Tests for New Drugs from Cancer to AIDS. In *Living and Working with the New Medical Technologies: Intersections of Inquiry.* M. Lock, A. Young, and A. Cambrosio, eds. Pp. 49–81. Cambridge: Cambridge University Press.

Mauss, Marcel. 1967 [1925]. *The Gift.* I. Cunnison, trans. London: Cohen & West.

Meltzer, S., L. Leiter, D. Daneman, H. C. Gerstein, D. Lau, S. Ludwig, J. F. Yale, B. Zinman, and D. Lillie. 1998. 1998 Clinical Practice Guidelines for the Management of Diabetes in Canada. *Canadian Medical Association Journal* 159 (Suppl. 8):S1–29.

Menzies, David. 2001. Loyalty, At All Costs: It Used to Be Consumers Based Their Choice of Products on Value, Price, and Convenience. Now, Thanks to Company Reward Programs, You Can Add Kickbacks to the List. In *National Post.* Pp. C1, C4. April 21.

Miller, Daniel. 1995. Consumption and Commodities. *Annual Review of Anthropology* 24:141–161.

———. 1998. *A Theory of Shopping.* Ithaca: Cornell University Press.

Nichter, Mark, and Nancy Vuckovic. 1994. Agenda for an Anthropology of Pharmaceutical Practice. *Social Science and Medicine* 39(11):1509–1525.

Parry, Jonathan, and Marc Bloch. 1989. Introduction. In *Morality and Money.* J. Parry and M. Bloch, eds. Pp. 543–548. Cambridge: Cambridge University Press.

Picard, André. 2001a. Six Million Lack Proper Drug Plans, Study Finds. In *Globe and Mail.* March 14:A1, A8.

———. 2001b. Spending on Drugs Up, Data Say. In *Globe and Mail.* March 15:A8.

Porter, Theodore. 1992. Objectivity as Standardization: The Rhetoric of Impersonality in Measurement, Statistics, and Cost-Benefit Analysis. *Annals of Scholarship* 9(1):19–59.

Povinelli, Elizabeth A. 1993. *Labor's Lot: The Power, History and Culture of Aboriginal Action.* Chicago: Chicago University Press.

———. 2000. Consuming Geist: Popontology and the Spirit of Capital in Indigenous Australia. *Public Culture* 31(3):501–528.

Q&A with Debra Lynkowski. 1999. *Diabetes Dialogue* 46:36–37.

Ralston, Jennifer. 2000. Beyond Pill Pushing: How Shoppers Drug Mart Positions Itself above the Pharmacy Fray. In *Marketing Magazine* 105(12):19.

Rasky, Frank. 1988. *Just a Simple Pharmacist: The Story of Murray Koffler, Builder of the Shoppers Drug Mart Empire.* Toronto: McClelland & Stewart.

Rock, Melanie. 2000. Discounted Lives? Weighing Disability When Measuring Health and Ruling on "'Compassionate" Murder. *Social Science and Medicine* 51(3):407–418.

———. 2003a. Deaths, Taxes, and the Midas Touch of Mary Tyler Moore: Accounting for Promises by Politicians to Help Avert and Control Diabetes. *Medical Anthropology Quarterly* 17(2):200–232.

———. 2003b. Sweet Blood and Social Suffering: Rethinking Cause-Effect Relationships in Diabetes, Distress, and Duress. *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 22:131–174.

Scheper-Hughes, Nancy. 1996. The Theft of Life: The Globalization of Organ Stealing Rumours. *Anthropology Today* 12(3):3–11.

Sharp, Lesley. 2000. The Commodification of the Body and Its Parts. *Annual Review of Anthropology* 29:287–328.

Strathern, Marilyn. 1992. Qualified Value: The Perspective of Gift Exchange. *Barter, Exchange, and Value: An Anthropological Approach.* C. Humphrey and S. Hugh-Jones, eds. Pp. 169–191. Cambridge: Cambridge University Press.

———. 1996. Cutting the Network. *Journal of the Royal Anthropological Institute* 2(n.s.):517–535.

Thomas, Nicholas. 1991. *Entangled Objects: Exchange, Material Culture, and Colonialism in the Pacific.* Cambridge: Harvard University Press.

Titmuss, Richard. 1971. *The Gift Relationship.* London: Allen & Irwin.

Turner, Bryan S. 1987. *Medical Power and Social Knowledge.* London: Sage.

United Kingdom Prospective Diabetes Study Group. 1998a. Effects of Intensive Blood Glucose Control with Metformin on Complications in Overweight Patients with Type 2 Diabetes. *Lancet* 352(9131):854–868.

———. 1998b. Intensive Blood Glucose Control with Sulphonylureas or Insulin Compared with Conventional Treatment and Risk of Complications in Patients with Type 2 Diabetes. *Lancet* 352(9131):837–853.

———. 1998c. Tight Blood Pressure Control and Risk of Macrovascular and Microvascular Complications in Type 2 Diabetes. *British Medical Journal* 317(September):703–713.

van der Geest, Sjaak, Susan Reynolds Whyte, and Anita Hardon. 1996. The Anthropology of Pharmaceuticals: A Biographical Approach. *Annual Review of Anthropology* 25:153–178.

Vuckovic, Nancy. 2000. Fast Relief: Buying Time with Medications. *Medical Anthropology Quarterly* 13(1):51–68.

Vuckovic, Nancy, and Mark Nichter. 1997. Changing Patterns of Pharmaceutical Practice in the United States. *Social Science and Medicine* 44(9):1285–1302.

Yang, Mayfair. 2000. Putting Global Capitalism in Its Place: Economic Hybridity, Bataille, and Ritual Expenditure. *Current Anthropology* 41(4):477–509.