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The Public Voice and the Nation's Health

Notes from Your Faithful but Beleaguered Participant Observer at the Battlefront

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I have begun to realize that I have based much of my academic career on ignorance. No doubt my colleagues knew this a long time ago, and I am just slower to realize it.

Not being employed by a provider or payor or regulator of medical care, and not being a physician, nurse, or dentist, I am frequently called upon in my capacity as a layman to represent the public on various committees and in various ways. In short, I have become a professional layman. There are not very many of us, and we are in great demand.

This role has a number of advantages. It allows one to ask a limited number of naive questions and get away with it, and this can be marvelous for one's personal edification. It allows one to make bald statements of opinion without any obligation to back them up by literature citations. The committee work, however, entails its moments of boredom listening to others' naiveté and opinion. At these times I am led to speculate on the role of the public voice in medical care. Such questions allow me to avoid asking myself such depressing questions as whether I am part of the problem or part of the solution.

**Author's Note:* The numerous prestigious organizations with which the author is associated or which pay his salary prefer that their names not be mentioned here.

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Exit and Voice

The public *Voice* can be contrasted with *Exit.* We must define our terms. A fine place to start is Albert O. Hirschman's book, *Exit, Voice, and Loyalty* (Hirschman, 1970), which attempts to reconcile economics (the marketplace) with political science (the polling place) as ways of making organizations responsive to the public's wishes.

Exit is the economist's model: if you don't like the care in Hospital A, go to Hospital B. If A's prices are too high and quality too low, it will not survive. *Exit* is the behavioral model that seems to drive the Federal Trade Commission (FTC) when it promotes competition through advertising and opposes such presumably collusive arrangements as fee schedules, which, it assumes, create monopoly and limit choice (Relman, 1978; Avellone and Moore, 1978; Geist, 1978).

Voice is control of organizations through votes and representatives, public and private. *Voice* by government includes the courts, government ownership, and legislation attempting to make private providers do the right thing. (Fig. 1). *Voice* is what other parts of the government are promoting through regulations, which usually conflict with what the FTC is attempting to do. For example, Federal law (PL93-222) purported to promote Health Maintenance Organizations (HMOs) but actually made them so expensive as to retard their growth. *Voice* by private organizations in health occurs through: 1) advisory committees; 2) trusteeship; and 3) government regulation of private providers. It is these three categories that I will

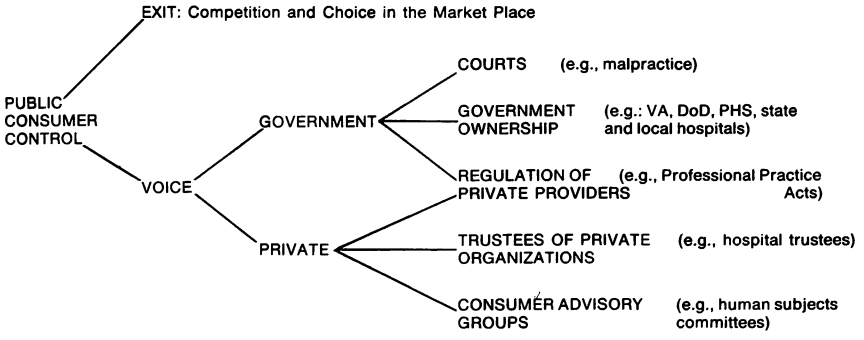

FIG. 1. Typology of control mechanisms assumed to make medical care providers responsive to public wishes.

address. The research method is participant observation in those settings which, needing my particular ignorance, chose to let me in. Each category is covered by a field study.

Advisory Committees

Human Subjects Committee

Such committees are required by the Department of Health, Education, and Welfare in hospitals that receive government money to do research on patients or volunteers. They are made up mostly of hospital personnel and are required to have a few token outside lay persons. The one I sat on for one year was associated with a distinguished (is there any other kind?) teaching hospital. We met once a month and reviewed about 15 to 20 proposals in a few hours.

Early on I became convinced that bad research is unethical, however harmless. So it is appropriate to inquire into research design as well as risks and benefits. Now, each one of these proposals was more technical than the last. Biomedical jargon enough to melt almost anyone's mind. There was no way even a professional layman like me could understand all these proposals. Risks were never stated as probability distributions. We would, sometimes by chance, discover that similar research had already been done. I imagine that less than half of what we approved was funded and carried out, and thus our efforts were just an intellectual exercise. These never-to-be conducted studies swamped the agenda sufficiently so the studies actually carried out got too little attention.

I have a general complaint about medical research. The purpose of research is just behavior change, and therefore the National Institutes of Health (NIH) should be managed by professors of marketing and Madison Avenue account executives. One can have very well designed research that changes nothing. The series of excellent trials from England on home-versus-hospital care for myocardial infarctions are an example (Hill, Hampton, and Mitchell, 1978). One can observe wide acceptance of procedures in the absence of good evidence, bypass surgery being an example. One can even trace both the rise and fall of procedures in the absence of good data; gastric freezing is a case in point (Bunker et al., 1977).

Good research should be measured by its impact on changing behavior, and that requires a careful measuring of the Bayesian priors of the people using a procedure, drug, or technique, as to its risks and benefits. The tolbutamide uproar is a good example of such a failure (Sheldon, 1971). That is why marketers should manage NIH, not researchers.

All of this brings me to internal mammary artery ligation. Everyone interested in medical experimentation and human subjects should read the 1959 trial by Cobb and associates (Cobb, Thomas, Dillard et al., 1959).

A total of 17 subjects were randomized—yes, just 17 subjects. Half were given this operation to relieve the pain of angina. The other half were given sham operations. Under local anesthesia, the artery was exposed. At this point, patients were randomized. The experimental group had the artery tied off. It was not tied off for the sham group. The follow-up evaluation was blind, and both groups showed equal relief from pain. Presumably, both groups were sent a bill for their care in order to keep the study blind. This procedure disappeared from use. Now sham operations are what human subject committees are supposed to stop, and presumably there aren't many done these days.[1]

We all owe a large debt to those eight people who received sham operations. Perhaps because of their sacrifice we lay people are no longer at risk of receiving this useless procedure. We failed to reward these eight subjects. They each should receive $1 million tax-free dollars and be flown to the White House to shake hands with the President. (Some experts say this procedure was obsolete by then anyway and would have been abandoned even in the absence of this trial. Therefore, these patients were sacrificed solely "for the record" and not to change provider behavior.)

We may be paying billions of unnecessary dollars because of our failure to perform sham operations. Consider coronary artery bypass surgery. We need a trial with sham operations to show how much pain is really relieved by the $14,000 this operation costs. This

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[1]The experts disagree on this. Anyone knowing of a study using sham operations currently underway at an institution may write a letter to the author describing it. A copy of this letter with an appropriate covering note will be forwarded to the tabloid newspapers in the writer's home town for publication there, where the correspondent will no doubt be given due credit for his or her contribution.

layman is all in favor of sham operations under either of the following conditions:

Proposal Number One. Investigators would go to an equivalent of Lloyds of London to purchase a no-fault insurance policy for their experiments. The awards would be standardized according to a schedule of payments (say, $500,000 for loss of a limb; $30,000 for a loss of a year of life; $250 for an extra day in the hospital). The cost of this policy would vary by reputation of investigator and hospital, and by the risks of the project. These insurance premiums would be part of the research grant proposal, and the NIH committee would have to weigh the costs and benefits for this against other proposals. The role of the human subjects committee would be to hand out awards for harm.

Proposal Number Two. A hospital would announce the fact that, say, one patient in 500 is likely to get a sham operation. At the end of the study, those people receiving the sham operation would each be given a large award, say $1 million apiece. The size of the award would relate to the length of the line of people waiting to get into the hospital. If the line is too long, the award is too high. Such odds would be far better than our State Lottery, which I dare say is less ethical than a good trial with sham operations well rewarded. A randomized trial of my two proposals is desperately needed.

Human subjects committees are to my mind a bad example of *Voice*. Let me further predict that they will not be changed because those millions of dollars that could be given as awards now go to professional researchers rather than to patients. My proposals would take money from the researchers and give it to patients for a net improvement in social welfare. Any professional layman can see that here *Voice*, badly expressed, serves the medical research establishment at the expense of the public.

Hospital Trustees

No two of the five boards I sit on are alike. The mere fact that I am foolish enough to sit on five boards and thereby subject myself to all sorts of law suits clearly demonstrates my ignorance, in case you have not already been convinced.

The first question any rational person should ask when invited to be a trustee is how much insurance coverage does the organization have to cover possible suits against trustees? The hospital must have such insurance to have rational trustees. Having this insurance means trustees do not fear public *Voice* expressed through the courts; such insurance thereby cuts off this arm of public *Voice.* The cost of this insurance is passed on to patients, who are the only ones who lose by the complicated and expensive arrangement. Here is a fine example of two *Voice* mechanisms working at cross-purposes to each other, thereby defeating both, and resulting in no benefit except in terms of profits to insurance underwriters and clear costs to patients and society.

I serve on the 12-person board of a Boston teaching hospital as an appointee of the Governor. For a century, the Governor has been allowed to appoint two of 12 board members. I take pleasure in imagining what kind of disreputable souls had been appointed in the past by one of our more colorful governors. Presumably, as a result of this, the board does close to nothing. If any important business is transacted, it is done without my knowledge by the three or four officers of the board in executive session. To demonstrate this, I wish to cite verbatim a recent vote of the board. This example is disguised to protect the guilty.

> The Board votes approval of the transfer of $67.42 from the Jerome Murphy Trust to the Fund for Liver Research.

After faithfully attending board meetings for a year, I have received no information on which to base a judgment of the quality of care in this hospital. I do have an idea about cost differences. A standard surgical procedure in this hospital costs $1100, while in a competing teaching hospital across town they do the same procedure for $500. The medical chief of my hospital tells me, in private, that there is no difference in the quality of care. No one, including the administrator, seems much concerned with this. Now, compare this in your mind with a for-profit corporation selling their widgets for $1.10 while their competitor sells a similar quality of widget for $0.50. Well, you get the point, I hope. (For those who don't know about widgets, hypothetical organizations talked about in business schools produce widgets.) Although this hospital is in a maelstrom of

important issues, the critical topic for this board is the complaint about a too-small parking lot.[2]

Let me compare this to another suburban hospital board. This hospital has a management contract with one of those investor-owned hospital chains. The board does nothing much here, either, but the hospital is very well managed. The administrator is driven nearly to the point of ulcers by the fiercely demanding, central corporate office of the chain. Prices have been cut for 2 years running, the average length of stay substantially reduced, and the ambulatory services become so busy as to overflow all available space. The third-party auditors, convinced of the wicked nature of these proprietary chains, double and triple check everything, so that this hospital can get away with a lot less than some of the famous voluntary hospitals in the area.

Now, don't get me wrong. I am not attempting to demonstrate the folly of voluntaries and the virtue of investor-owned chains. (There is the question of whether investor-owned hospitals are efficiently managed in the achievement of socially inappropriate objective functions.) The greatest contribution of the investor-owned hospitals may be to tighten up management practices in the voluntaries. This would be a great service for us patients. Unfortunately, it will show up unfavorably in their "bottom line," as their voluntary competitors shape up. This is just one more perverse incentive in the medical care industry.

What I am trying to say is that a management contract with an investor-owned chain is an excellent substitute for an apathetic board of trustees. What is needed in hospitals is the equivalent of the stock proxy battle in corporations to keep the board and administration on their toes.

I would like to propose that any voluntary hospital selling its basic service for $1100 while others sell it for $500 would be automatically subject to a 5-year management contract "takeover." This could be one good role of public *Voice* through the state regulatory agencies. Anyone demonstrating such a price difference would go before the regulatory agency. If this agency agrees that the difference is real, then bids will be let on a management contract for

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[2]To be fair to this fine organization, in the past few months most of these issues have been addressed and are being corrected.

that hospital, and the lowest one will get it. In the government sector, one or two Veterans Administration (VA) hospitals should be managed by such contracts, as a test of VA system performance.

Not all boards function badly. Others are active and do good work in my humble opinion. (Harvard professors rarely have humble opinions.) Several months ago, I discovered that four famous health economists in Boston serve on hospital boards. (This would not have been the case even 5 years ago.) They have written eloquently on the problems of inflation in the health field—some of them have even done so in this distinguished journal. We all met for lunch once. Although this was a group who have studied the inflationary effects of individual hospital decisions, once they got involved in individual hospitals they felt pressured to give up their system-wide view and join their fellow board members' local chauvinism to be biggest and best. They are pressured to participate in those decisions to buy CT Scanners and heart surgery services in order to beggar their neighbors and us taxpayers. It all goes to show the powerful forces of institutional loyalty.

Public Voice—Regulation

There was a brief and passing moment in my school when it was thought that the faculty should descend from its ivory tower and help solve the problems of the "real world." An associate of mine and I tried to do so by being neutral intermediaries for a battle between optometrists and ophthalmologists in our state over a bill the optometrists were supporting to allow them to use topical anesthetics for glaucoma testing. I was badly burned in this bitter political war fought with a veneer of mutual politeness.

Neither eye group was particularly interested in using research to answer this question. The ophthalmologists cited horror stories of wicked behavior on the part of the optometrists, who replied in kind before various state legislators, some of whom are very intelligent, and some of whom I doubt understood any of it or much cared.

If there is no evidence worthy of the term "scientific" and no desire to obtain any, how does one decide who is right or how the public might best be served other than to vote for the side that offers you the biggest bribe? If legislators are dishonest, it is we who make them so.

Put yourself in the position of a state legislator. All day long you are talking to the truckers who want the tolls lowered, to the unions about closed shop, to the racetrack owners, the liquor store owners, on and on. Each group is wrapping up its narrow economic interests in motherhood and the flag. Then the eye doctors come in trading insults. What is the legislator to think, other than that these people are like all the rest, fighting over who will get the nickle?

Their behavior affects all health professionals who appear before legislators. The next time you appear before a legislator, think how you can distinguish yourself from the dog track owners and beauticians. Will it be by the quality of your evidence? It is a great wonder to me how few corrupt legislators there are under these circumstances. It must be very hard to maintain one's altruism while confronting this endless stream of mercenary petitioners.

My associate and I must have appeared as exotic birds—do-gooders, here today and gone tomorrow. What the legislators needed was persistent objectivity. The public *Voice* in the State House is weak, indeed, when it comes to the technical details of medical care delivery.

Loyalty

Neither *Exit* nor *Voice* works without *Loyalty*. The *Exit* model of the competitive marketplace suggests that an infinitesimal lapse in cost or quality on the part of Hospital A will instantly drive all its patients into Hospital B. Hospital A would go bankrupt, drop out of the competition, leaving Hospital B with a monopoly and therefore with no economic need to be responsive. *Loyalty* keeps a sufficient number of patients coming to A to keep it in the market.

The *Voice* model needs *Loyalty*, too. The board and committee members must take the trouble to complain in order to make things better. Trustees with too little *Loyalty* to attend board meetings fail to make their *Voice* heard to everyone's detriment.

We are a long way from fully understanding when *Exit* works or fails to work and when *Voice* works or fails to work in medical care. Further work needs to be done in this area. If someone is willing to pay me to do this research, I may even give up my amateur (lay) status and really turn pro.

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