

MEDICAL HUMANITIES REPORT

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Health Reform: The Enemies Within

by Leonard Fleck, Ph.D.

Ignorance, Apathy, Antipathy and Avarice: These are the four horsemen of the apocalypse of health care reform. And unless these destructive forces within us are vanquished, they will destroy the most substantial and comprehensive plan for true health reform in U.S. history.

This year in the United States we will spend about \$2.5 trillion on health care, about 17 percent of our gross domestic product. Given this current growth path, by 2018 we will be at \$4.4 trillion, about 20 percent of our likely GDP. Western Europe spends about 10 percent of its GDP on health care and gets overall better health outcomes that include universal coverage. That would suggest they know something we don't. This is not a time for allowing American pride to cover up American ignorance.

We have an extraordinarily fragmented health care system, both in terms of the delivery and financing of health care. This generates extraordinarily high administrative costs, as much as 22-24 percent of all health care dollars spent in the private sector. These dollars fail to purchase any health care services, either for the insured or uninsured. European nations have comparable administrative costs of about 12 percent; the Medicare program has administrative costs of 6 percent. A proposed public plan with administrative costs close to Medicare looks like a very good buy that might force private insurers to achieve substantial organizational efficiencies and spend more health care dollars on health care services. Ranting about government waste and inefficiency looks like willful ignorance.

The health care cost curve must be bent downward if we are to have

sustainable health reform. How should that be accomplished? Free market advocates espouse the value of competition. Unfortunately, the economics of health care are quite different from economics outside health care. A year ago a Michigan hospital announced its intent to invest \$160 million in building a proton beam accelerator to treat prostate cancer and some other cancers a bit better. Within a week, four other Michigan hospitals announced their intent to do the same (to remain competitive). This would be a hugely inefficient and misdirected use of limited health care resources. Failure to recognize the limits of efficient competition represents ideologically-driven ignorance. Health reform that fails to recognize and address such ignorance will fail.

Apathy is best friends with ignorance. If I am very well insured, why should the 47 million without health insurance be my problem? Why should I endorse health reform aimed at denying insurance companies the right to deny health insurance to those with pre-existing conditions? Those are the high cost individuals who are driving up the cost of health insurance; they need to take more personal responsibility for themselves (not me). Answers to these questions are best formulated by the 5 million newly unemployed over the past year, most of whom are now without health insurance. The former owner of a factory in Elkhart, IN might also provide an informative answer. In a recent CNN report he was forced to sell his \$14 million mansion in Florida for \$2.5 million, which left him entirely bankrupt. The story did not reveal his health insurance status. Maybe he was old enough for Medicare. If not, he has a serious problem; apathy is

not his friend.

The Institute of Medicine estimates that 22,000 Americans die prematurely every year as a result of lack of health insurance. Most often this occurs because these uninsured individuals defer seeking medical care for early treatable medical conditions (early stage cancers) that become untreatable with time. But if I am well insured, this too is not my problem. If such apathy cannot be converted to empathy, then health reform will surely fail.

Antipathy is another faithful comrade-in-arms of ignorance. The problem of health reform is extremely complex because it requires expert knowledge (medical, technical, economic, organizational) as well as moral sensitivity and political wisdom. What is the proper role of government in bringing about health care reform (universal coverage and health care cost control)? What does it mean to be a just and caring society when we have only limited resources (money) to meet virtually unlimited health care needs (multiplied and magnified in urgency by expensive new life-prolonging medical technologies)?

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The same individuals who assert as a supreme moral directive that human life is priceless refuse to pay the higher taxes necessary to achieve universal coverage, thereby continuing to overlook those 22,000 annual deaths associated with lack of health insurance. This is properly seen as an internal moral and political conflict for each and every one of those individuals, but what we have witnessed over the past few weeks is its expression as animosity toward those who would seek to muster the social intelligence and balanced moral sensibilities needed to think through the complexities of health care reform. Democratic societies thrive on democratic deliberation: reasonable, rational, respectful public engagement, even in matters where there is deep moral and political disagreement. Accusing advocates of health care reform of being enthusiastic euthanasiasts reflects a degree of rhetorical righteousness deficient in both reason and respect. If this sort of egregious animosity cannot be excised from democratic forums, health reform will fail (and the larger political experiment that is American democracy will be put at risk as well).

Avarice is the last of the threats to health care reform. No doubt there are greedy lawyers, greedy doctors, greedy hospitals, greedy insurers and greedy pharmaceutical companies. But these entities are all generally agents for others. They can only advance their own avaricious interests by working assiduously to advance the avaricious interests of others, you and I, either as patients or as taxpayers/ insurance premium payers. We demand (if we are insured) \$100,000 cancer drugs that will give us a few extra weeks or extra months of life. We demand \$2,000 MRIs for our tension headaches because we have a vague anxiety it might be brain cancer. We demand \$200,000 left-ventricular assist devices for our failing hearts for an extra year of life.

We hide from ourselves our own greed by asserting with suitably blustering moral outrage that human

life is priceless (when someone else is paying those costs), while at the same time failing to muster so much as a syllable of moral outrage in defense of the pricelessness of the lives of the uninsured. We disguise from ourselves our own disingenuousness when we denounce greedy insurers who deny us marginally beneficial, excessively costly health care services while we collectively deny the uninsured all the very effective and very cost worthy health care interventions they need. Health care reform that is affordable and sustainable will require health care cost containment, marginal sacrifice of marginal benefits by all of us. If we are incapable of this degree of minimal mutual sacrifice, greed will surely defeat health care reform.

Call to mind images of America that capture our noblest commitments and ideals. Call to mind Iwo Jima, the moon landing, the civil rights movement, all of which required substantial, sometimes ultimate sacrifices. Health reform requires small sacrifice by each of us for the benefit of all. A society that aspires to be just and caring for all its members is capable of that degree of sacrifice; however, deciding precisely the mechanisms for accomplishing that will require respectful, rational, democratic deliberation. That in turn will require banishing from the political landscape those four horsemen within each of us and the threat of political destruction they represent.

The Center Welcomes

Monir Moniruzzaman, recently joined the Center for Ethics and Humanities in the Life Sciences as well as the Department of Anthropology as an assistant professor. Monir is a Ph.D. candidate at the University of Toronto. His research explores the illegal organ bazaar, particularly the experiences of kidney sellers in Bangladesh. Part of his work has been transformed into a successful art installation piece, which was exhibited in a Toronto art gallery. Monir

has been awarded a CIHR strategic fellowship at the Health Care Technology and Place as well as a Comparative Program on Health and Society doctoral fellowship at the MUNK Center for International Studies at University of Toronto. His current research interests include organ commodification, new biomedical technology, bioethics, medical tourism, and post-tsunami health in Thailand.

Jin Kyong (Regina) Kim, a researcher in the Center for Humanities and Life Culture at Dong-A University in Korea, joins our Center this year through MSU's Visiting International Professional Program. Regina's research interests include ethics of the patient-physician relationship, decision making in life-sustaining treatment, and understanding and applying the concept of futility and health care policy.

MEDICAL HUMANITIES REPORT

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Town Classrooms before Town Halls

by Ann Mongoven, Ph.D., M.P.H.

Recent national discourse on health care reform has been so uninformative and ugly that it gave birth to new political jargon: “the toxic town hall.” Toxic town halls have taught us what kind of conversation we do not want to have on health care reform. What kind of conversation DO we want to have? What kind of democratic processes or citizen virtues can support it?

Despite toxic town halls, I am an optimist that we can answer those questions to support deliberative public discourse on health reform. Underlying my optimism is the civic model of my students at Michigan State University. Last fall, in a course entitled “Election 2008 and the Nation’s Health,” 150 MSU students accepted the explicitly framed challenge of fostering classroom conversation of the kind they would like to hear in broader public. In an atmosphere of civic friendship, they maintained a sophisticated conversation that dramatically contrasts with the shouting matches of the evening news. They developed a factually accurate picture of our health care system; articulated its successes, failures, and challenges; framed a range of alternative policy options; and weighed inevitable trade-offs among them. These accomplishments are necessary prerequisites to any consensus-building on how to address our crumbling health finance and delivery systems. My MSU students are our teachers.

These are the lessons my students offer to the general public:

- Ground rules for discourse matter
- Facts matter
(Corollary: myths matter)
- Stories matter
- Imagination matters
- Ranges of policy options matter
- Basic values may not matter as much as we think.

Ground rules for discourse matter. Our class faced this belatedly, after one iso-

lated but traumatic incident during which defense of alternative viewpoints devolved to questioning of character. In response, we cancelled the week’s planned activity of small breakout discussion and instead addressed the incident and articulated ground rules to support our ideal goals for discourse. Students showed great courage in these discussions, sharing anger, hurt, disappointment and a critical assessment of responsibility. The list of ground-rules that resulted was pragmatic and considered things such as: who speaks when, who gets the microphone, how the room is set up, and who is in charge of enforcing ground-rules. In course evaluations, this conversation, rather than any specific aspect of the course syllabus on health care, was the most frequently cited contribution of the course. If we wish to make civic “lemonade” from the “lemons” of toxic town halls, some parallel consideration of ground rules must take place not only for town-hall meetings, but for multiple diverse sites of democratic discourse.

Facts Matter. (Corollary: Myths Matter). My students were fact-builders and myth busters. The course began by quizzing students on some basic facts about our health care system. Questions focused on recognized parameters of cost, access, and quality. Audience response technology assisted this process and students could anonymously answer, and then visually see the class profile mapped against the correct answer.

Many students were aware of indicators demonstrating lack of access to care, such as the number of uninsured (we are, after all, in Michigan). But the class as a whole dramatically erred on cost and quality indicators. At first they grossly *underestimated* costs, wrongly assuming other industrialized nations spend much more per capita on health care than the U.S. while the reverse is true. And they grossly overestimated quality as that is measured by various

outcome measures (such as infant mortality) and process indicators (such as percentage of common cancers detected in early stages). Indeed, there were audible gasps when they saw the U.S.A.’s actual international standings on these matters.

This visual reality-check galvanized the students. They wanted to spend more time learning descriptively about the U.S. health care system than I had originally allotted. While some town hall rhetoric poses the health systems of other nations as one monolithic kind of system—one demonic Other—my students pressed for more detail in our overview of different kinds of health systems, weighing what they saw as advantages and disadvantages.

Many in the general public are debating health care reform on the basis of the very factual misconceptions my students came to question. My students taught that the “background” to health policy issues is really the foreground. Gaining a descriptive understanding of current health care financing and delivery is a challenging first task for citizens.

Perhaps we need town classrooms before town halls. Both parties in Congress could contribute to a public syllabus. For example, they could create a jointly endorsed “fact sheet” of the combined cost, quality, and access indicators that portray a national crisis. They could also include a vocabulary “cheat-sheet” that explains, for example, that Medicare and Medicaid are not the same program; that “a national health plan,” “universal coverage,” “single-payer systems,” and “socialized medicine” are not equivalent terms; that “bending the cost curve” is a good rather than illicit dream. We should all be able to agree on some parameters of the challenge before us, even if not immediately on solutions.

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Comparative Effectiveness Research: What is it? What is its Role in Health Care Reform?

by Margaret Holmes-Rovner, Ph.D.

What is Comparative Effectiveness Research (CER)?

In general, comparative effectiveness research (CER) represents a move toward increased emphasis on research that 1) compares an intervention against its best or most commonly used alternatives in practice rather than against a placebo and 2) addresses effectiveness rather than efficacy. Effectiveness means evaluating interventions in real-world patients, rather than in the highly selected patient groups who receive study-related care in the usual randomized control study. Another effect of CER is that by comparing realistic alternative treatments, the analysis shows the size of the benefit to be gained by using more effective treatments. Thus, CER may facilitate discussions about the adoption of expensive therapies that provide marginal (increased) benefit.

The reason for emphasizing effectiveness and comparisons with next-best alternatives is a pragmatic one. CER is intended to guide decision-making of patients, providers, and payers in the real world. The most current guidance about the generation and support of CER is contained in a recently published report from the Institute of Medicine (IOM), *Initial National Priorities for Comparative Effectiveness Research*.¹ In the IOM National Priorities report, the formal definition of CER is:

The generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels. (p. 9)

This definition leads the IOM Committee to identify six characteristics of research that fulfill this mission. These six characteristics may come from experi-

mental studies, observational studies, research synthesis, comparative effectiveness systematic reviews, formal meta-analyses, and technology assessments. All may provide important data. However, experimental studies are the most expensive to conduct, and should be reserved for questions that cannot be answered through synthesis of existing research. The six characteristics of CER identified by the IOM Committee are:

- CER has the objective of directly informing a specific clinical decision from the patient perspective or a health policy decision from the population perspective.
- CER compares at least two alternative interventions, each with the potential to be “best practice.”
- CER describes results at the population and subgroup levels.
- CER measures outcomes—both benefits and harms—that are important to patients.
- CER employs methods and data sources appropriate for the decision of interest.
- CER is conducted in settings that are similar to those in which the intervention will be used in practice.

The IOM’s main charge, in addition to providing definition, was to identify national priorities for study topics. The resulting 100 topics can be found on the IOM website.² The topics cover a broad range of issues that were generated by a consensus process conducted with a diverse set of stakeholders. The arbitrarily chosen example of Women’s Health gives a flavor for the kinds of issues identified:

Women’s Health Priority Topics

- WH-A Compare the effectiveness of innovative strategies for preventing unintended pregnancies (e.g., over-the-counter access to oral contraceptives or other hormonal methods, expanding access to long-acting methods for

young women, providing free contraceptives methods at public clinics, pharmacies, or other locations).

- WH-B Compare the effectiveness of clinical interventions (e.g., prenatal care, nutritional counseling, smoking cessation, substance abuse treatment, and combinations of these interventions) to reduce incidences of infant mortality, pre-term births, and low birth rates, especially among African American women.
- WH-C Compare the effectiveness and outcomes of care with obstetric ultrasound studies and care without the use of ultrasound in normal pregnancies.
- WH-D Compare the effectiveness of birthing care in freestanding birth centers and usual care of childbearing women at low and moderate risk.
- WH-E Compare the effectiveness of different strategies for promoting breastfeeding among low-income African American women.

What are the pitfalls of CER?

A frequently expressed concern is that CER holds the same danger that some see in evidence-based guidelines, namely that coverage decisions will be made that only cover the least expensive alternative, and that “one size fits all” care ignores individuals, both providers and patients. The IOM report argues that this is a common misapprehension. The committee argues that CER done well should give providers the means to tailor their choice of treatment to the individual patient’s characteristics and preferences. The hope is that better information can help providers do a better job of matching their care to an individual patient’s needs.

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Perspectives on: **Overworked and Underpaid: Primary Care, Professional Integrity, and the Promise of the Patient-Centered Medical Home**

In the last issue of the MHR, Misha Strauss, Ph.D. wrote about the Patient-Centered Medical Home and practitioner integrity. The contributors to this InkLinks continue this discussion. InkLinks is a regular column in which readers reflect on issues related to the previous lead article. It is meant to tap the rich intellectual resources that this network provides. We welcome your contribution at altimare@msu.edu.

The Ethical Potential of PCMH

Strauss concludes her essay with two questions about practitioner integrity, which she believes the PCMH helps to answer in the affirmative. Interestingly, Timothy Daaleman offers a complementary set of philosophical arguments that both justify and challenge Strauss's conclusion. Drawing on the work of Alasdair MacIntyre and others, Daaleman claims that the PCMH has the potential to serve as the focal point of a more ethical medical practice. By recognizing and enhancing the internal goods of medical practice through patient-centered and coordinated longitudinal care, the PCMH offers the essential institutional support needed to cultivate the virtues of practitioners. Likewise, Edmund Pellegrino has consistently argued in favor of a model of patient care that is predicated on a covenant of trust in which the physician ensures that her competence will be used toward the well-being of the patient. It is only within such a medical practice that a virtuous physician is empowered to practice with excellence. In my mind, the PCMH supports this ideal. Thus, the PCMH seems to be a promising venue for both ethical practice and for the mentoring and training of physicians.

Despite these promises, there remain significant threats to the ideals of the PCMH. In resonance with Daaleman, I believe the most significant threat will emerge as PCMH models are adapted by for-profit providers and reoriented toward external goods of medicine, to use MacIntyre's term. In the past few years, large managed care companies have turned to the PCMH model to enhance both patient satisfaction and profitability, often at the request of large

corporate clients who hope to reduce insurance costs for their employees.

The worry I have is that the core values of the PCMH will no longer be based on the internal goals of medicine—i.e. the well-being of the patient—but will too easily shift toward prioritizing profit increases or cost savings. With this shift, the PCMH may founder on the same rocks as health management organizations of the 1980s, as primary care providers become or are perceived as gatekeepers who control access to specialists and are conflicted in their dual role as caregivers and as de facto home managers. Thus, an additional question emerges: Can the PCMH live up to its ethical potential when there are potential profits in the mix? The answer to this question seems less clear.

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For references:
<http://bioethics.msu.edu/>

The Family Centered Medical Home

I would like to add a pediatric perspective to Dr. Strauss's report. The concept of the medical home originated in pediatrics in 1967 and the term was coined by the American Academy of Pediatrics. Fundamental to the original concept was the proposal that every child with special health care needs would have a central repository of health records as a means to combat the fragmentation of care so often experienced. The concept persisted in pediatric care and evolved into a model that is accessible, compassionate, coordinated, comprehensive and culturally effective.

Over the years, many pediatricians

have been providing a medical home to their patients. They have been doing so as lone rangers, champions and "super docs" despite the delivery system in which they work. These activities have been accomplished at considerable expense in terms of time and money.

Family physicians and internists officially embraced the concept of the medical home when their professional organizations endorsed the joint principles in the spring of 2007. They added a component that pediatricians omitted: adequate reimbursement as an essential component of the medical home model. Our colleagues in internal and family medicine were clear, "we won't do it if we aren't paid for it." Thank you to the internists and family docs.

Dr. Strauss comments that reimbursement in medicine is largely procedure driven and that primary care doctors boost revenues through patient volume. An important component of the PCMH is a change in reimbursement so that payment is no longer strictly tied to procedures or encounters. If we want care to be coordinated and comprehensive, we need to create a system that pays for the effort needed behind the scenes.

Additionally, I would like to comment on the difference between the Patient Centered Medical Home (PCMH) espoused by docs for grown ups and the Family Centered Medical Home (FCMH) of pediatrics. The obvious difference is that adults often visit the doctor alone and the patient-physician relationship is one-on-one and children are usually accompanied by a family member so the core relationship has multiple parties.

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News & Announcements

JUDITH ANDRE and LEONARD FLECK and ANN MONGOVEN

Presentations

- “Teach In–Health Insurance Reform” for sponsored educational session, Michigan State University (September 2009)

ELIZABETH (LIBBY) BOGDAN-LOVIS

Presentations

- “Evidence-based Medicine Penetration in Latin America” as part of “Health Related Behaviors and Well Being in Latin America: Public Health Training and Needs” panel session, organized by MSU Latin American and Caribbean Studies (September 2009)

MARGARET HOLMES-ROVNER

Publications

- Holtrop JS, Stommel M, Corser W, Holmes-Rovner M. Predictors of Smoking Cessation and Relapse after Hospitalization for Acute Coronary Syndrome. Forthcoming. *J Hosp Med*. 2009 Mar;4(3):E3-9.
- Elwyn G, O’Connor AM, Bennett C, Newcombe RG, Durand M, Drake E, Joseph N, Khangura S, Politi M, Saarimaki A, Sivell S, Stiel M, Bernstein SJ, Col N, Coulter A, Eden K, Harter M, Holmes-Rovner M, Moumjid N, Perez L, Stacey D, Thomson R, Whelan, Wiejden T, Edwards A. Assessing the quality of decision support technologies using the International Patient Decision Aid Standards instrument (IPDASi). *PLoS ONE*. 2009;4(3):e4705. Epub 2009 Mar 4.
- Dunn SL, Stommel M, Corser WD, Holmes-Rovner M. Hopelessness and its effect on cardiac rehabilitation exercise participation following hospitalization for acute coronary syndrome. *Jl. Of Cardiopul. Rehab*, 2009; 29:32-39.

GERALD S. SCHATZ

Honors

- A ridge in Antarctica's Ellsworth Mountains, south of the Antarctic Peninsula, has been named the Schatz Ridge, in recognition of his work in that region. The nomination was by the U.S. Advisory Committee on Antarctic Names, accepted by the Board of Geographic Names, of the U.S. Geological Survey, and accepted by the international community via the international Scientific Committee on Antarctic Research.

MISHA STRAUSS

Presentations

- “Drawing the Line: Professionalism, the Patient-Healthcare Worker Relationship, and the Establishment of Appropriate Boundaries” for Chelsea Community Hospital, Chelsea, MI (September 2009)

Appointments

- Member, Saint Joseph Mercy Health System Board Quality Committee (July 2009)

TOM TOMLINSON

Presentations

- “Protection of Non-Welfare Interests in the Research Uses of Archived Biological Samples,” for Bioethics Seminar and Webcast, University of Toronto (September 2009)

Publications

- "Protection of Non-Welfare Interests in the Research Uses of Archived Biological Samples," in *New Challenges for Biobanks*. Ethics, Law and Governance, eds. Kris Dierickx & Pascal Borry. Antwerp: Intersentia. (October 2009)

Appointments

- Member, the Bioethics and Medical Humanities Journal Club

(FCMH from page 5)

But there is another more fundamental difference in the philosophies underlying the models. Family centered care means: 1) the family (in the broadest interpretation of what constitutes a family) is recognized as the primary source of strength for the child or youth, 2) family members are experts on the health and needs of the child, and 3) family members share in decision making about the child's health care and

family members have input into how health care is delivered. A FCMH has processes in place for families to have input into the policies and procedures of the practice.

The PCMH is patient centered in the sense that the health and wellbeing of the patient is the central goal. Also, the patient is expected to take an active role in promoting his or her own good health. However, the PCMH is *doctor driven* and meaningful input from the

patient is lacking. We have a long way to go before we can honestly say the patient is the center of our system of care. In contrast, the ideal FCMH is truly family/patient centered and the physician is just one member of that team.

Jane Turner, M.D.
College of Human Medicine
Michigan State University

(TCTH from page 3)

Stories matter. Getting an accurate descriptive understanding of our current health care system, or non-system, is not only a matter of gathering facts narrowly understood. It is also a matter of hearing each others' stories. In our class, false and negative stereotypes of who is uninsured and why could not survive hearing stories from fellow students, many of whom described lack of access to medical care in their families. We benefit not only from personal stories, but from stories told by different field perspectives. How do economists, or historians, or cultural anthropologists, or political scientists, or medical organizations, or demographers, tell the story of U.S. health care? How do those stories overlap or diverge in their articulation of problems or successes?

Many students reported being greatly piqued to learn that major features of the current U.S. system resulted from historical accident rather than design. Or that economists consider physician-licensing a form of economic monopoly. Or that some things we commonly call "disease" may not be recognized as such in other places and times, while some conditions that we do not think of as problems are called "disease." How should these stories inform the story we will all write together in future health care policy?

Imagination matters. It is understandable for people to be fearful when the public debates who should receive what medical care, who should pay for it, and how. But public challenges of cost, quality, and access remain continually unmet if citizens are paralyzed by personal fears, futilely trying to see into the crystal ball which policies will ultimately maximize their personal benefits. Collective paralysis based on personal fears makes everyone worse off. My students taught me that we need imaginative exercises to yank us out of this paralysis.

Role-playing is one of several such imaginative strategies. If one role-plays being a Medicare program trustee, as my students did, many prominent questions of current discourse become moot—

such as whether one is a liberal or a conservative, whatever those terms mean. The question becomes bankruptcy or solvency. It's that stark, since the Medicare program will go broke within in a decade if current trends in medical cost inflation remain unchanged. Paradoxically, by personalizing public challenges, role-playing helps imaginative citizens to move beyond personal fear.

Ranges of policy options matter. My students taught me the importance of sketching full ranges of policy options before focusing debate on specific proposals—another step harmfully skipped in public debate. Policy options at the focus of current public attention represent a narrow swath on the full spectrum that have been tried internationally, or in domestic experiments, or that have been proposed by health policy analysts. Without any sense of the broader range of options, citizens have no orientation from which to compare and contrast, weigh strengths and benefits, or to devise new options.

The image that comes to mind is that of someone parachuting down into one of our vast national parks without a map. So this park-hopper looks around and says, "I fell here so this campground must be the center of the park." We need a full-range policy map and we need to do some hiking to survey it. This map will be helpful even if only a narrower range of options proves politically practicable.

Basic values may not matter as much as we think (thank goodness). Often one hears people say "we can't fix health care until people's basic values change." But my class experience challenged that. At three points in the course, we used the audience response system to ask/repeat basic questions about values, such as whether one thinks of health care as a right or what should be the primary goal of the health care system. Unlike with the fact questions, there was virtually no change in the class answer-profile as the semester progressed. Yet students converged on common perceptions of cost,

quality, and access challenges. And in response, most students increased the range of policy options they saw as considerable. So maybe we don't have to change people's basic values to fix health care. Maybe people don't have to become, or claim to become, more like me in order for us to fix a common problem. Don't most of us feel ambivalent about our basic values anyway? For example, we may want the health system both to provide the greatest good for the greatest number *and* to protect the most health-vulnerable, though those goals compete for resources. In fact, few citizens may be as disastrously consistent as philosophers. And most citizens' values may encompass basic concern for others and for future generations.

My class suggests we should stop asking fellow citizens to have conversion experiences on basic values and instead start helping each other to understand facts, myths, stories, common challenges, and the range of options about health care. That may be enough to garner a consensus on some constructive response to the challenges of health cost, quality, and access.

Philosophers often look to ancient Athens for inspiration on democratic ideals. But I think we may need to look more to Sparta. Thank you to my MSU students for being such Athenian Spartans. And such good teachers to the public at large.



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Upcoming Brown Bags

November 11, 2009

12-1:00 p.m.

C-102 East Fee Hall

Catherine Belling, Ph.D.

“Pandemic Flu Preparedness and the
Uses of Narrative”

December 9, 2009

12-1:00 p.m.

C-102 East Fee Hall

Monir Moniruzzaman

“‘Living Cadavers’: The Ethics of Human Organ
Commodification”

(CER from page 4)

A related question is whether or not comparative effectiveness research can inform debate in ways that cost-effectiveness research frequently has not. In countries where a cost-effectiveness threshold has been set to “rationally” determine coverage, as well as in the US where insurance companies must make coverage based on the best evidence they have, both the press, and clinicians call foul and protest that any constraint on access to care is detrimental to patients’ health. There may be an opportunity through CER to come closer to reaching consensus about how much is too much to pay for interventions that produce small benefits and have harms that can also be described.

Medical care can be plagued by false positives and false negatives. A false positive in healthcare results in a patient that is needlessly treated, while a false negative is a patient that misses out on a helpful treatment. Payers bear the bulk of the cost for false positives, while the individual patients bear the bulk of the

cost of false negatives. Providers remain the advocates for patients, and join them in discounting the high cost of health care false positives, particularly in the face of denial of access to specific treatments or screenings.

Can CER help with Health Care Reform?

There are a number of ways in which CER can at least inform the health care reform debate. The first is that simply making a list of areas in which comparative effectiveness data are needed should increase transparency about what is known and what is not known about what works in health care, and *how well* interventions work. The full IOM CER report fully describes the process by which they reached the priority list. This, in itself, should inform the debate. A related aspect of increasing CER is that providers, patients, and payers can talk simultaneously across venues about concrete examples. Finally, it is encouraging that the IOM report emphasizes

research on infrastructure development for providing CER information to patients and providers in clinical settings, and on translational priorities in addition to the outcome information needs on specific clinical topics.

¹ Copies of *Initial National Priorities for Comparative Effectiveness Research* are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area); Internet, www.nap.edu.

² 100 Initial Priority Topics for Comparative Effectiveness Research. <http://www.iom.edu/CMS/3809/63608/71025/71032.aspx>