

Kerr White's Acceptance of the Baxter Prize

(To be delivered at Baxter Foundation Prize Award Dinner on June 8, 1996 and read by Clifford Gaus)

KLW's Remarks at the Baxter Foundation Ceremony:

Professor Carter-Haddock, Mr. Staubitz, Mrs. Morgan, Mr. Fernandez, Deborah, colleagues, and guests: I regret greatly that serious family responsibilities prevent me from being with you this evening. Nevertheless, I will be thinking of all of you on what for me is a most auspicious occasion. In my absence I have asked my former student and long-time friend Cliff Gaus to read these short remarks.

Let me start by expressing my deep appreciation for the honor bestowed on me with this award by the Baxter Foundation, the AUPHA, and its Baxter Prize Selection Committee. I was truly stunned when Deborah Freund telephoned me a few weeks ago with the news that an old goat like me was to be the recipient of this prestigious prize. From the bottom of my heart I thank you all ever so much.

When something like this comes your way it is well to remember that many others have preceded you. As a friend of mine remarked: "If you see a tortoise on top of a fence post, you know that it didn't get there by itself!" Accordingly, I thought you might be interested in several examples of the origins of ideas that I and others have espoused over recent decades.

For many years I have stressed the central importance of the Placebo Effect and the Hawthorne Effect in health care enterprises at the individual, institutional, and system levels. Together these two ubiquitous phenomena seem to account, on average, for about one-half of the benefits from all health care interventions. People "feel better" after they have made a decision to put themselves, for example, in the hands of a physician, nurse, or hospital. "Caring is Part of the Cure" read the buttons worn by everyone in a campaign at Johns Hopkins, twenty years ago.

When I was a graduate student in the Department of Economics at Yale many years ago Eliot Dunlap Smith, Professor of Industrial Management, introduced me to the central role of the Hawthorne Effect in the management of almost any human enterprise. For those not familiar with the Hawthorne experiments conducted in the 1930s by Harvard investigators at AT&T's Western Electric plant of the same name let me briefly describe them. Essentially these classic studies showed that when employees perceived that the company "cared", no matter how the investigators altered the work-place environment, productivity always improved. Since then the Hawthorne findings have been implemented in the industrial world by most progressive organizations. Unfortunately health care managers only recently have started to employ these seminal ideas. There can be little doubt, however, that the Hawthorne Effect is relevant to all service and "caring" enterprises.

Years later in 1959 I met Professor Reginald Revans, Professor of Operations Research, at the University of Manchester. Recognizing the importance of the Hawthorne effect he showed in a several studies, after controlling for other variables, that the attitudes of management and supervisory personnel had a direct influence on the turnover of nurses and other staff and, perhaps of greater importance, on patients' length of hospital stay for a variety of common illnesses in several hospitals. The more authoritarian and controlling the management the greater the labor turnover and the longer the length of stay. Conversely, the more supportive and constructive the management the lower the turnover and the shorter the length of hospital stay. The impact of managerial attitudes and behavior on the quality of care, patient satisfaction, and costs immediately are apparent.

Elliot Dunlap Smith and Reginald Revans also introduced me to the power of thinking by analogy or "lateral thinking" as expounded later by Edward de Bono in several volumes. In the 1960s I thought often about the disarray in America's health care arrangements and compared our plight with solutions such as the governmentally sponsored National Health Service in Britain. It seemed to me that the United States was too large and diverse to have a single monolithic health care system.

So what are the alternatives if one objective is to provide seamless service from home care, through primary, specialist, hospital, nursing home, assisted living, and hospice care? The prevailing arrangements at that time involved a series of horizontal cartels consisting of doctors, nurses, hospitals, nursing homes, etc. Too often, they had little to do with one another and, indeed, were sometimes in open conflict. By a process of lateral thinking I began to consider models such as large vertically integrated oil companies and airlines. Both provided ideas about the way in which America's health care system might evolve. No oil company would think of limiting its staff to petroleum geologists and chemical engineers with no distribution system and no service stations. No airline would have a fleet consisting only of Concorde and 747s. Although much good has resulted, those in charge of America's health care system placed excessive emphasis on tertiary care hospital services. They ignored other essential modalities required for a balanced system such as primary care, community hospitals, assisted living, and home care. From the standpoint of organizational evolution the airlines seemed the more apt model. They started as barn-stormers and crop-dusters and then consolidated into regional airlines and finally emerged as the mega-carriers that dominate the present system. Surely our health care would evolve in similar fashion over the decades. In 1967 I gave a talk to the American Association for the Advancement of Science that described vertically integrated health care systems. I suggested that these would start locally and regionally and consolidate gradually into ever larger entities until the country ended up with seven or eight competing national systems. Some would be owned by investors, others by labor unions, insurance companies, doctors, or investors, etc. In a series of articles and talks over the next few years I discussed what came to be referred to by others as the "Airline Model" for organizing health care systems. Overall little attention was paid to the idea at the time but it resurfaced in later years. I still think this is the way we will end up. The idea stemmed from the observations and teachings of Elliot Dunlap Smith and Reginald Revans.

In 1959, under the tutelage of Professor Jerry Morris of the London Hospital Medical School, I first encountered the work of Alison Glover. In the 1930s Glover published a series of papers describing large differences in the population-based rates for tonsillectomies in school children living in comparable cities in Britain. Demonstration of these differences came to be known as the "Glover Phenomenon". Jerry Morris himself had documented substantial differences in case-fatality rates between London teaching and non-teaching hospitals. The former had substantially lower rates for a number of common disorders. From Glover's and Morris's work it seemed to me that if one could develop state-wide and even national hospital discharge data for all patients in a population-based jurisdiction there might be all kinds of comparisons to be made. Accordingly when the University of Vermont asked me to develop a Department of Epidemiology and Community Medicine, I seized the opportunity. My top priority was the installation in all Vermont hospitals of what was then the Professional Activities Analysis System for abstracting discharge summaries. This was accomplished after much blood, sweat, and tears, including the charge that I was a communist! A couple of years later at Johns Hopkins, I encouraged Jack Wennberg, then a student, to take a job in Vermont to exploit that state's hospital discharge abstract data. The rest is history but the original idea came from Alison Glover and Jerry Morris.

It should also be recalled, however, that Florence Nightingale first suggested about 1860 the implementation of a Uniform Minimum Data Set for hospital statistics. Later E. A. Codman of Boston was castigated by his colleagues when he made similar proposals at the beginning of this century. These ideas led us to the Airlie House Conference of 1968 from which evolved the Uniform Minimum

Hospital Discharge Data Set. Strong resistance from many quarters to publicizing what hospitals did with what results and at what costs delayed widespread implementation of Florence Nighingale's ideas for a further 17 years. The Airlie House Conference was followed by similar exercises for Ambulatory and Long-term Data Sets. I can still recall Cliff Gaus sitting in his office at Hopkins working on his doctoral thesis in a state of great consternation. He was busily coordinating several data sets for Allegheny County saying that if he was ever in a position to influence such matters he would see that population-based data sets were implemented for all health care activities.

My point in all this is to suggest that not all the good ideas are new and perhaps not all the new ideas are that good! I doubt that I have ever had an original thought of my own but I have been fortunate to rub shoulders with those who showed me new and different ways to think about health care problems. Their tutelage and examples helped me to struggle towards the top of the fence-post, albeit temporarily, where you honor me tonight.

Let me close by telling you how far the field of Health Services Research has come in the last forty years. An early colleague in the field had a son who was starting school. On the first day of the new school year the teacher inquired, among other matters, about each child's address and father's occupation. When asked about the latter my friend's child replied: "My father plays the piano in a bawdy house". The startled teacher had the child confirm his father's occupation. Later that day the teacher called on her pupils' families. She confronted my friend's child's mother by repeating the child's statement about his father's occupation. The mother replied that the teacher shouldn't be concerned. "My husband doesn't want the children to be embarrassed by his work so he tells them to say that his job is to play the piano in a bawdy house. Actually he does Health Services Research."

I am ever so sorry I could not be with you. Once more I thank the Selection Committee, the Baxter Foundation, and the AUPHA for the great honor they have done me.