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La liberté des médecins en question

Médecine, liberté et Vernon Smith

La décadence des systèmes de santé inspirés de Marx et de Bismarck s'accompagne d'atteintes flagrantes à la liberté professionnelle du médecin. Dans notre pays, les cartels de la santé et leurs relais escamotent au préjudice des jeunes médecins, les garanties constitutionnelles régissant la liberté d'entreprendre. Ils dépouillent les praticiens d'outils précieux tels que le laboratoire ou la radiologie. Ils téléguident la prescription, chronomètrent la consultation, dictent la durée d'hospitalisation. Le contrôle des coûts dérive vers un contrôle de tout et de tous, à n'importe quel prix.

Il n'est pas dans notre propos de pleurer ici l'autonomie médicale perdue. Les paradigmes économiques changent et avec eux, les cadres institutionnels. Une nouvelle génération d'économistes, qui emprunte sa méthodologie aussi bien à la psychologie qu'à la neuroscience, se porte de manière inattendue au secours de la liberté thérapeutique. Prix Nobel d'économie en 2002, le Professeur Vernon L. Smith est un pionnier de cette science économique nouvelle. Partant d'un modèle de double accès à l'innovation pharmaceutique, conçu par son compatriote Bart Madden, il s'exprime dans une interview exclusive accordée à notre journal, sur les synergies entre médecine et économie expérimentale.

Pour les nouveaux économistes, le libre choix est une valeur essentielle de progrès. En recentrant la science économique sur l'individu, ils remettent fondamentalement en question l'archaïque modèle planificateur qui asservit le médecin et rationne le malade. Avec Vernon Smith et ses disciples, médecine et économie se retrouvent sur un terrain humaniste commun. Le médecin s'affranchit des nébuleuses bureaucratiques qui dénaturent sa mission. Il retrouve son poste au service exclusif de patients souverains.

Dr Alphonse Crespo

Sommaire

Ce qu'en pense…

Jean Martin, ancien médecin cantonal, membre de la Commission nationale d'éthique

Pour avoir longtemps et avec passion observé médecine et société et y avoir œuvré, je suis convaincu que le corps médical a un rôle civil spécifique à jouer et que sa liberté est fondamentale. Je ne veux pas d'un docteur de droit semi-divin sur son piédestal mais attends qu'il prenne des positions publiques fortes voire dissidentes, si les principes d'une communauté que nous voulons à la fois libérale – au sens large – et solidaire sont remis en cause, si des personnes vulnérables n'obtiennent pas les soins et le soutien dont elles ont besoin.
De plus, je crois à deux maximes: «la liberté des uns s'arrête là où commence celle des autres», et «la liberté ne vaut que par les limites qu'on accepte de lui mettre».

Libre choix thérapeutique

Dialogue avec V. Smith, Prix Nobel d'économie

L'économie expérimentale explore les comportements économiques individuels en appliquant une méthodologie empruntée à la psychologie. Dans une interview exclusive accordée au Dr Alphonse Crespo pour le *CMV*, le professeur Vernon Smith, Prix Nobel d'économie 2002 et pionnier dans ce domaine, évoque les mécanismes décisionnels qui guident médecins et patients dans leurs choix. Il se penche également sur un modèle expérimental qui propose aux médecins et à leurs patients une voie d'accès plus rapide aux nouveaux médicaments, indépendante des processus administratifs d'enregistrement *(Dual Tracking)* ainsi qu'une base de données ouverte, *(Tradeoff Evaluation Database)* destinée à faciliter la pondération individuelle des risques/bénéfices liés aux produits en cours d'expérimentation.

Nous vous remercions de faire l'effort de lire ce texte dans la langue d'origine de l'auteur. Une version résumée en français se trouve sur le site www.svmed.ch, rubrique presse.

How could experimental economics contribute to health care?
Experimental economics is concerned with the application of laboratory and field experimental methods to the study of individual decision making, and to market, management and other group decision processes. This includes the subfield of Economic System Design – constructing and testing new such processes.

Health care is about[1] private patient-physician decision making under uncertainty about diagnosis and treatment regimens, and[2] public decisions about what rules should govern processes such as the approval of new drugs for the treatment of disease.

Experimental methods can be used to help us understand some of the behavioral issues in both private decision making, given the rules, and the compa-

rative evaluation of proposed new institutions (governed by different rules), based on differential responses by individuals when deciding under alternative rules. Notice the inherent duality between studying individual performance (choice) governed by fixed external rules, and studying system performance by asking how individual choice might be altered when you change the institutional rules. Although most of the basic studies have originated in the laboratory, experimentalists are interested always in field studies and other methods concerned with issues of robustness.

Cognitive psychologists like Daniel Kahneman at Princeton, and Gerd Gigerenzer at the Max Planck Institute (Berlin) have long studied decision making under uncertainty. Kahneman's work showed that people's choices, where there was a prospect of gain, behaved very differently from choices where there was a prospect of loss. Thus a person might prefer 10 for sure to a 50-50 chance of gaining 20 or nothing, but prefer a 50-50 chance of losing 20 or nothing to a sure loss of 10. This work established the importance of this type of asymmetric «bias», or «loss avoidance».

Such «biases», however, need not imply that a decision is irrational. For example, important themes in Gigerenzer's concept of ecological rationality is the human use of heuristics – like, «keep promises» – that may serve us well in most circumstances, but are not the result of mindful calculation.

Again, Roy Radner at New York University has asked how the theory of uncertain investment decisions is altered if the decision maker is concerned with rationality in the sense of maximizing the probability of survival rather than the standard assumption of maximizing the expected utility of wealth. He proves that for a survivalist there is a critical level of wealth below which, given a choice between two investments with the same expected (mean) outcome, he will choose the one with the larger instead of the smaller variance (at higher wealth he would have chosen the lower variance prospect). This is because the prospect of a large gain can mean survival in a situation where he has too little wealth to survive financially and meet essential withdrawal obligations.

This way of thinking about decision – the economics of survival – may have particularly important implications for

Le professeur Vernon Smith

health care decisions. One's «health state» is a type of «biological wealth», and is subject to cumulative factors that are related to age, and the physical and social environment, as well as health decisions.

What is the «Dual Tracking» model of access to new medication and why should both doctors and economists support it?

There are two core principles in approaching problems in Economic System Design[1]: all decision making under uncertainty involves two kinds of error[2]; in all systems important sources of information are decentralized. Bart Madden's «Dual Tracking» systems design model of access to new drug medications recognizes the following two sources of error in considering the harm that any drug testing-approval process can cause. There is the error of approving a drug that may have safety and efficacy risks, and the error of failing to approve in a timely manner a drug that can prevent disease or deaths that are already occurring under existing therapies. Why is the balancing of these two errors politically difficult for public agencies like the Food and Drug Administration (FDA)? Very simply, any drug that survives FDA screening procedures, and causes disease, injury or death is likely to generate negative publicity for the agency, and calls for the FDA to «do something» to prevent reoccurrence.

Alternatively, drugs that are delayed (the FDA process averages over eight years of delay) and that are found efficacious will fail to prevent injury or death for those who are not treated. Even if such injurious events are common they are neither visible nor newsworthy, although in aggregate they can cause large amounts of unnecessary suffering. The tradeoff in these two types of error is inherent in the uncertainties of treatment based on new medical knowledge. Everybody can be doing his or her job, faithfully following the rules, but as medical knowledge improves those rules may need to be reevaluated to address the imbalance between the damages caused by these two types of error.

Madden argues that the FDA's regulatory procedure fails in not allowing some individuals to express their willingness to incur risk to achieve potential health improvement, given their personal circumstances, as evaluated in consultation with their physician.

Moreover, there is no feedback mechanism to evaluate the benefits versus costs of the FDA's expensive and lengthy approval process (See 3 below).

The first component of Madden's proposal is a "dual tracking" mechanism. On one track, a new drug continues along the conventional FDA clinical-testing procedures. This means that all drugs to be marketed as FDA-approved must successfully pass a Phase I (safety) trial, fol-

lowed by Phase II safety as well as effectiveness testing in a small sample of patients, followed by a Phase III clinical trial with a much larger number of patients. Perhaps the vast majority of patients and their physicians will await the result of that process.

On a separate private track independent of the FDA, new drugs that have passed Phase I safety trials can be bought by suitably informed consumers (patients with advice from their doctors) by legally contracting with drug developers. Patients and their doctors could choose either FDA-approved drugs or new drugs still in clinical trials. This separate track corresponds to an option like that existing prior to 1962, when new drugs had to pass only safety trials to be marketed legally. Effectiveness was left to consumers and doctors to evaluate, much as non prescription drug therapies – surgery, physical therapy, diet, exercise, over the counter medications, etc., any of which can be dangerous for some individuals – are left for patients and their physicians to choose today. Hence, this track is not in any meaningful sense a radical departure from either past or current therapeutic practices.

Economists are likely to support dual tracking because they will appreciate that it enlarges individual choice alternatives. It is important, however, to caution that Track II places a special burden on the individual to educate and inform himself in consultation with his or her doctors. For doctors it strengthens the patient relationship and provides important new tools to further treatment success and reputation building.

Dual Tracking would enable patients and doctors to have access to comprehensive and timely information on not-yet-approved drugs. How would this improve present research, development and market access of therapeutic drugs?
The second component of «Dual Tracking» is a Tradeoff Evaluation Database (TED) that allows new sources of decentralized information to be collected and made available. TED would provide convenient internet access to up-to-date information about the risks of adverse side effects and potential health improvements, beginning with Phase I safety trials. A TED website would be available to doctors to input data that tracks clinical details on the treatment and response measures for all patients who have enrolled under the Track II program. This would provide a new specialized data base that would supplement Phase I testing results, and any parallel controlled clinical studies of the same drugs that are continuing in Phase II and III testing. TED would be specialized in the sense of being limited to patients who self select into this alternative track. Such patients are more likely to be desperate cases of serious disease, injury, or with advanced carcinomas, and so on. Hence, it would provide a supplement to, not a substitute for, Phase II and III randomized trial testing data. ■