Subverting criteria: the role of precedent in decisions to finance surgery

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Abstract
This paper investigates prospective utilisation review for tympanostomy. In the studied procedure, a medical corporation reviews cases for third-party payers (insurance companies), and used explicit criteria to determine whether a case is appropriate for surgery. Earlier findings that inappropriate decisions to approve surgery are strongly related to previous surgeries for the same condition are investigated to trace the emergence of this theme within the review process and its consolidation into a ‘precedent’ for further surgery, notwithstanding the explicit criteria which the reviewers are mandated to enforce. The significance of previous surgeries as a factor favouring further surgery emerges at all levels of the review process, indicating a medical culture that validates precedent in medical decision making despite the absence of evidence-based findings that would support it.

Keywords: managed care, utilisation review, quality assurance, medical decision making, physician communication

Introduction

In their classic description of the acculturation of medical students into the ways of medical practice, Becker et al. (1961) noted the central position of clinical experience in medical decision making. Based on the physician’s personal, firsthand experience in observing, diagnosing, and treating patients, clinical experience was seen as both fundamental and necessary for any competent physician. Indeed, clinical experience was understood to
be preferable to abstract scientific evidence or ‘book learning’ as a basis for clinical judgment. As Becker et al. wrote:

Clinical experience ... gives the doctor the knowledge he needs to treat patients successfully, even though that knowledge has not yet been systematized and scientifically verified. One does not acquire this knowledge through academic study but by seeing clinical phenomena and dealing with clinical problems first hand. Clinical experience, even though it substitutes for scientifically verified knowledge, can be used to legitimate a choice of procedures for a patient’s treatment and can even be used to rule out use of some procedures which have been scientifically established (1961: 231).

In the 40 years since Becker and his colleagues wrote, there have been repeated efforts to systematise medical decision making and reduce the amount of variation in the diagnosis and treatment of patients (Berg 1997). From standard practice guidelines and computer-based protocols to decision analysis and evidence-based medicine, each effort to systematise medical decision making is ultimately designed to address concerns that clinical experience alone is insufficient as a basis for diagnosis and treatment decisions; a more rational, evidence-based system is also necessary (Berg 1997).

Despite these consistent efforts by a variety of institutions, including clinical societies, third-party payers, and government agencies, many physicians continue to substitute clinical experience even when it contrasts with scientific knowledge. This paper examines the pervasiveness of appeals to clinical experience in the context of utilisation review, one recent effort to systematise and rationalise medical decision making in the United States. Specifically, we focus on the use of precedent, meaning by this the belief that because one has used a procedure in the past with a particular patient, one is justified in using the same procedure again for the same patient in a similar condition. In this use of precedent, the fact that the patient’s condition justified a procedure in the past is treated as a transparent argument for a similar claim in the present. Thus, buoyed by precedent, the past use of a procedure can serve as a self-evident justification for its use in the future. This notion of precedent may lie at the heart of various ‘medical myths’ – practices or procedures that are maintained, and often promoted, even though they have no basis in the scientific literature.

In this paper, we focus on a commitment to a medical precedent that appears to be entrenched in the culture of otolaryngologists: the belief that prior tympanostomy surgery warrants subsequent tympanostomy surgery in the same patient, even in the absence of evidence to support such a conclusion. We examine the presence and functioning of this belief in the context of prospective utilisation review – a bureaucratic process in which attending physicians must justify the need for tympanostomy surgery to the
medical representatives of insurance companies. Prospective utilisation review (UR) is an attempt to restrict treatments to patients who are most likely to benefit from them, and to minimise the use of inappropriate procedures which waste resources and represent poor quality health care. In our data, prospective UR involves the implementation of explicit criteria which must be met to approve cases for surgery. This is a context in which justifications for surgeries, including the use of precedent, are densely present.

Our paper begins with a description of the review process, the medical condition, otitis media, for which tympanostomy tube insertion was proposed, and the data on which our analysis is based. We then examine the ways that an orientation to prior surgeries permeates the review process, and, finally, we consider how the myth of prior surgery may provide for accountability in the context of the review.

**Prospective utilisation review and the process of rationalising decisions**

Utilisation review is one method by which third-party payers can control health care costs either by requiring physicians to try alternative, less expensive treatments first or, as in this case, by attempting to limit the use of medical procedures or technologies to those clinical circumstances for which they are most likely to be effective, based on current knowledge and expert belief. The UR firm we studied was a national firm that contracted with various third-party payers to conduct prospective utilisation reviews for a variety of surgical procedures, including tympanostomy, tonsillectomy, arthroscopy, haemorrhoidectomy, hysterectomy, and carpal tunnel surgery. The UR firm convened panels of clinical and academic experts to develop explicit criteria to be used to determine the appropriateness or medical necessity of the proposed procedure. In this UR firm, appropriateness was defined as situations in which the expected health benefits would exceed the expected negative health consequences by a sufficiently wide margin (Kleinman et al. 1994, Kleinman et al. 1997). The reviews were prospective: cases that failed to meet the criteria were not covered by the third-party payer and the surgery was not likely to be performed.

The UR firm used a two-step process to evaluate proposed surgeries. In the first-level review, a nurse-reviewer conducted a telephone interview with a member of the attending surgeon’s (ENT/otolaryngologist’s) office staff who read from the patients written chart. These interviews were guided by an interactive computer programme, using a smart logic branching algorithm, designed such that each answer to a question prompted another question until a ‘threshold’ was reached and the case was approved for surgery.

Cases that were not approved for surgery at this level, approximately 30 per cent of the cases in the time period we examined, were forwarded...
to the second-level review in which a physician-reviewer interviewed the attending physician by telephone. The purpose of the second-level review was to determine the existence of any new information (that was not contained in the written record) or any extenuating circumstances that would override the criteria (such as the presence of certain conditions that were not included in the first-level review protocol, e.g., Down’s syndrome or cleft palate). At this time, the physician-reviewer had available for consultation the ‘paper trail’ from the first-level review – a computer-generated listing of the protocol (interview) results; a list of the criteria necessary to approve the case; and any additional summary handwritten notes from the nurse-reviewer. Thus, in each instance, the reviewer had the data in advance of the interview to know which aspects of the case were sufficiently problematic for the case to fail the first-level review.

During the review, the reviewer’s tasks, as defined by the UR firm, were to verify the accuracy and completeness of the information gathered in the first-level review, to identify and assess the criterial relevance of any new information offered by the surgeon, and to identify and evaluate any potentially extenuating circumstances that might bear on the appropriateness of the surgery. On the basis of any new or additional information, the reviewer either overturned the first-level review and recommended the case for surgery or sustained the first-level review and did not recommend the case for surgery. Cases not recommended were eligible for appeal.

Otitis media and its treatment

All the cases under review in this study involved patients who suffered from otitis media, a condition characterised by the build-up of fluid or the development of infection in the middle ear. Otitis media is the most commonly diagnosed ailment in children, affecting some two-thirds of American children by the age of two and accounting for more than 14 per cent of all visits to the paediatrician, and more than 20 per cent of all visits to the otolaryngologist (Kleinman et al. 1994).

Otitis media generally takes two forms: acute otitis media (AOM) and otitis media with effusion (OME). Acute otitis media involves active infection, and generally includes symptoms such as fussiness, pain or fever. It generally resolves after a course of antibiotic therapy, but may frequently recur (Bluestone and Klein 1988; Kleinman et al. 1994). Otitis media with effusion (also known as ‘serous’ or ‘secretory’ otitis media (SOM)) involves the presence of fluid in the middle ear but the ear itself is not inflamed and there is no active infection. OME may arise spontaneously, or as a sequela of AOM. It may lead to fussiness or temporary hearing loss, but is frequently asymptomatic. OME frequently resolves spontaneously or with a single course of antibiotic therapy.
Although young children are especially vulnerable to middle ear infections because of anatomical immaturity, otitis media is not generally considered a serious health threat. AOM’s main symptoms, fever and/or pain in the ear, can cause distress in young children, but in most cases do not represent a serious hazard. There are a few very infrequent suppurative complications of otitis media, which may result in permanent hearing loss. Temporary hearing loss commonly occurs during the period when fluid is in the middle ear: controversy exists as to whether this is associated with significant delays in language development. The natural history of otitis media is that the severity and frequency of illness moderates with increasing age.

An alternative treatment to antibiotic therapy is the surgical insertion of tympanostomy, or pressure equalisation (PE) tubes (also known as grommets). These are small plastic or metal prosthetic devices that are inserted into the ear to help manage persistent effusion or recurrent infections. PE tubes function by assisting the Eustachian tube to maintain equal pressure on both sides of the ear drum (Bluestone and Klein 1988). At the time of insertion, fluid or accumulated material is usually drained by the surgeon. The insertion of PE tubes for otitis media is extremely common, with some 670,000 surgeries conducted in 1988 in the US, making it the most common operation for children (Kleinman et al. 1994). Typically, PE tubes will remain in the ear for a period of up to two years. Though they are normally extruded spontaneously, surgical removal is occasionally necessary. The annual cost of tympanostomy tube surgery to the US health care system exceeds one billion dollars annually (Cantekin et al. 1991).

Despite their pervasive use, however, the benefits of PE tubes are uncertain. According to some researchers, antibiotic treatment is equally effective in managing otitis media and is both less costly and less risky than surgery2 3. For this reason, as an overall strategy of cost containment, some health plans now require certain standards of prior treatment, such as a course of antibiotics or watchful waiting, before reimbursement for tympanostomy surgery4. The UR firm in this study implements such requirements for third-party payers, requiring otolaryngologists to meet certain criteria (involving clinical and treatment history) before reimbursement. Gathering information regarding prior treatment and clinical symptoms constitutes the focus of the utilisation review described here.

The data

The data for this study come from a stratified random sample of 108 audio-taped reviews, conducted by telephone, between 13 physician-reviewers and 108 specialists (10 primary care physicians and 98 otolaryngologists). The physician-reviewers, representing a California-based, national utilisation review (UR) firm, were board-certified specialists in either otolaryngology,
paediatrics, or internal medicine. All were licensed to practice medicine in the state of California.

The attending physicians under review had proposed the surgical insertion of tympanostomy tubes for the management of recurrent acute otitis media or otitis media with effusion. The physicians were located throughout the country. The audio recordings were made as part of the record-keeping routine of the UR firm, and all the doctors were aware of the recording. Patients agree to prospective or retrospective review as a part of their personal insurance contracts. The tape recorder was under the control of the reviewer and was, in most instances, switched on as contact with the doctor was established. Names and identifying characteristics of the physician-reviewers, the attending physicians under review, and the patients have been changed.

This sample was drawn from a total population of 5214 tympanostomy cases reviewed by the UR firm between 1 April, 1990 and 31 July, 1991 for three national third-party payer organisations (i.e. health care insurance companies) covering some 5.6 million Americans. Of these 5214 reviewed cases, 1448 (or 28 per cent) were found to be inappropriate after a first-step review (described below). Of these cases, 942 were reviewed by physician-reviewers who were employed by the UR firm. These 942 cases form the core sample from which the calls analysed in this study were drawn. The sample was stratified by type of appeal available and relative volume of cases handled by each reviewer. Low-volume reviewers were over-sampled to increase reviewer variability. The sample was also stratified by outcome or decision, with 71 cases approved for surgery, 31 cases denied, and six cases decision-deferred pending confirmation of history from the referring physician. For this paper, 12 cases were eliminated from the sample, 6 which had no decision (or decision pending) and 6 with incomplete records.

The average length of a review was approximately four minutes. The shortest call lasted about one minute; the longest stretched to 12 minutes.

The criteria

The criteria used by the reviewers in determining the appropriateness of surgery were developed by the UR firm, based on the recommendations of a panel of national experts (5 paediatricians and four otolaryngologists). This panel synthesised the current literature on the medical management of otitis media, in order to develop a set of evidence-based explicit criteria for tympanostomy. Using the two-round modified Delphi process developed by Brook et al. (1986), 80 specific clinical scenarios were evaluated as potential indications for surgery, and were rated on a nine-point ordinal scale with the following interpretation, 1–3 inappropriate, 4–6 equivocal or uncertain, and 7–9, appropriate. The criteria were to be applied to those clinical findings that could be documented by the physician or by the medical record.
The reviewers were mandated to be oriented by these criteria as they made determinations regarding the appropriateness of surgery. The attending physician under review consulted the patient’s clinical record, as needed, to answer the reviewer’s questions about symptoms, diagnosis, and treatment. Factors such as the age of the child, the presence of fluid in the ear (effusion) and its duration, amount of hearing loss, the frequency of AOM, type of antibiotic treatments, the presence of learning or developmental difficulties, and exceptional circumstances (such as cleft palate or Down’s Syndrome) were possible indications for surgery.

These criteria combine in a variety of ways. For example, otitis media with effusion [OME] involves a combination of some 64 indications. Age is the first indication: patients under age three were subject to different criteria than were patients over age three. Duration of effusion (how long the patient had fluid in the ear) is the second indication – any duration less than 60 days, regardless of other factors, would be found inappropriate. Marked otoscopic findings (upon physical examination, whether the middle ear shows retraction pockets and/or the absence of air bubbles) was the next indication, followed by a hearing loss of at least 25 db (as measured by an audiogram) and a trial course of antibiotics (of at least 10 days). Complications of otitis media were a further set of indications, and included acute mastoiditis, facial palsy, meningitis, and brain abscess. Table 1 shows a range of values of indicators for otitis media with effusion, and the guidelines for their evaluation in relation to surgery.

For example, as shown in Table 1, a patient over the age of three, with a history of otitis media for 120 days, mild otoscopic findings, and a trial course of antibiotics would be approved for surgery; while a patient under three, with mild otoscopic findings, with a history of more than 120 days of effusion, and no antibiotics would not be approved. A patient over the age of three, who has had an effusion of 95 days, a normal hearing test, and a trial of antibiotics would be approved for surgery; a child over three, who has had 120 days of effusion, a hearing loss of 25 db, but no antibiotics would not be approved. A child with acute mastoiditis, meningitis or brain abscess would be approved regardless of other indications, as would a child with Down’s Syndrome or cleft palate. These last patient characteristics were not included in the algorithm, but were considered extenuating circumstances that should overturn the first-level decision upon their discovery by the reviewer. It should be noted that, consistent with the medical literature, the expert panel did not include a prior history of treatment with tympanostomy tubes as relevant to assessing the appropriateness of current proposals for surgery.

The outcome of the review process is the reviewer’s recommendation to the insurance company as to whether tympanostomy tubes are appropriate for this patient at this time. The recommendation either supports the conclusions of the first-level review that the case is inappropriate, or overturns it. Although reviewers neither approve nor deny care directly, for the sake
of clarity we use these terms to describe their recommendations. These recommendations, which are frequently described in these terms by the reviewers themselves, are normally conveyed to the attending physician at the end of the phone call.

**Rationalisation versus precedent**

As one strategy for controlling the costs of health care, the reviews examined here represent an incursion into the previously unregulated area of clinical judgment. They represent an effort to rationalise decision making about tympanostomy tube surgery by means of explicit criteria which the reviewers have contracted to implement. However, despite the fact that outcomes

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should strongly correlate with the explicit criteria, they do not. While the reviewers never recommended against surgery that the criteria would support as appropriate, they frequently approved surgeries that the criteria would have denied. Of the 66 cases in our data set that they approved for surgery, 47 (71 per cent) did not meet the UR firm’s criteria (Kleinman et al. 1997: 499). Table 2 uses logistic regression to model the major factors predicting the reviewers’ decisions to overturn the negative first-level review and approve the case for surgery.

Table 2 demonstrates that a history of previous tympanostomy tube surgery is strongly associated with a reviewer’s recommendation in favour of surgery, even when controlling for the level of appropriateness. To examine this finding in more detail, we turned to the written records that summarised each review, and to audiotapes of the second-level reviews themselves.

The recorded data

We collected detailed data on 96 cases. The data included:

1. The print out from the computer-guided first-level review between the nurse-reviewer and the ENT’s office staff. Included with the print out were handwritten notes which the nurse-reviewer made on a scratchpad and incorporated into the case record;

Table 2: Factors impacting positive reviewer recommendations for surgery

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio</th>
<th>95% Confidence interval</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.03</td>
<td>0.78–1.36</td>
<td>.83*</td>
</tr>
<tr>
<td>Appropriateness rating</td>
<td>4.55</td>
<td>2.02–10.25</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Female sex</td>
<td>8.15</td>
<td>1.23–53.84</td>
<td>.03</td>
</tr>
<tr>
<td>Clinical severity†</td>
<td>1.02</td>
<td>1.00–1.03</td>
<td>.01*</td>
</tr>
<tr>
<td>Excess duration††</td>
<td>1.95</td>
<td>1.06–3.58</td>
<td>.03</td>
</tr>
<tr>
<td>History of prior tubes</td>
<td>30.94</td>
<td>2.43–394.81</td>
<td>.01</td>
</tr>
</tbody>
</table>

* These three variables have a defined relationship with the criteria and are included in this model only for the purposes of controlling for confounding while evaluating the other three variables.
† Clinical severity represents an interaction between the duration of effusion and the frequency of acute otitis media.
†† Excess duration represents, in 30-day intervals, the length of time that an effusion was asserted to have been present in excess of the documented duration of the effusion. This variable is included as a marker for the effect of undocumented clinical assertions on the outcome of the review.

2. Tape recordings of the second-level telephone reviews between the UR firm’s reviewers and the attending ENTs (surgeons), in which a decision regarding the medical necessity of the proposed surgery was reached;
3. The notes the physician-reviewers made justifying their recommendations made at the conclusion of their calls.

Results

Of the 96 cases examined, 44 per cent (42/96) of the patients had previously had tympanostomy surgery and 83 per cent (35/42) of these were approved for additional surgery. As Table 3 shows, references to these patients’ prior surgeries surfaced at every point in the review process, despite the fact that the criteria for approval did not include prior surgery.

Table 3: Where were previous PE tubes mentioned

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse 1st level review scratchpad*</td>
<td>32/96 (33.3%)</td>
<td></td>
</tr>
<tr>
<td>During the clinical discussion**</td>
<td>41/96 (42.7%)</td>
<td></td>
</tr>
<tr>
<td>As part of the verbal decision rationale</td>
<td>10/96 (10.4%)</td>
<td></td>
</tr>
<tr>
<td>Physician 2nd level review notes justifying the final decision</td>
<td>33/96 (34.4%)</td>
<td></td>
</tr>
<tr>
<td>Total number of cases in which there has been previous surgery***</td>
<td>42/96 (46.9%)</td>
<td></td>
</tr>
<tr>
<td>Total number of reviews</td>
<td>96</td>
<td></td>
</tr>
</tbody>
</table>

* Does not include three cases in which the nurse notes indicate that surgery had previously been approved, but not performed.
** Includes three cases in which the reviewer asked about prior tympanostomy surgery, and found that there had been none.
*** Based on written records associated with these cases, and the review telephone conversations.

It is noteworthy that references to prior surgeries emerged both in the written records produced by the nurses performing the first-level review, and in the reviewers’ notes on the second-level reviews. Discussion of prior surgeries were also an extensive and lively feature of the telephone reviews themselves, and emerged both in the clinical history of the case, and in the final section of the discussion between the reviewer and the attending physician during which the reviewers announced their recommendations and described the rationales for them.

During the first level review:
Evidence for the significance of a prior history of tympanostomy tube surgery in the clinical culture we studied initially emerges in the first-level review. Although we do not have recordings of these conversations, we do
have the results of the computer-assisted interview together with the nurse’s ‘scratchpad’ notes. The scratchpad provides an opportunity for the reviewing nurses to note factors that they or the attending physician’s office staff consider important, or which they think the reviewers will find relevant, and which are not addressable directly through the computer-assisted portion of the interview. The nurses made scratchpad entries documenting prior surgery in 32 of the 42 cases in which prior surgery had occurred, or just over three-quarters of them.

Typically, these observations were unstressed and embedded in a general narrative of the patient’s condition, as in (1):

1. Nurse scratchpad notes (Case #1949)
   
   **Dx:** Middle ear infection  
   **Hx:** Tubes inserted 11/28/89  
   *Seen in MDO 03/21/90 Tubes dry*  
   **PE** 09/07/90 tympanic membrane dull. Right tube out  
   *O hearing test done*  
   *No documentation as to when tube fell out*  
   *No otitis media documented since last November.*

In other cases, however, the summary was more emphatic in its representation of previous PE tube treatment, as in (2):

2. Nurse scratchpad notes (Case #1149)

   **DX:** OM with effusion  
   *This will be the patient’s third set of tubes*  
   8/21/90 (L) OM with effusion, wick placed. Patient was placed on Ceclor  
   10/90 (R) ear ok, (L) som placed on ceclor  
   11/90 Both ears were clear  
   3/25/91 mother called: patient has bilateral ear pain without fever  
   3/27/91 child was seen dx: OM with effusion  
   *Last hearing test 11/90.*

While the notes in (2) appear to suggest the role of antibiotics in clearing the patient’s condition, others imply a more significant role for the previous PE tubes, as in (3) and (4):

3. Nurse scratchpad notes (Case #4650)

   **DX:** (R) middle ear infection  
   *Patient has had previous tubes*  
   *Last tubes were placed 11/88*  
   4/90 (R) tube was blocked  
   6/90 Ears were clear and the patient was doing well  
   10/90 (R) tube was out and effusion was present, tympanogram was
flat and mild conductive hearing loss was present on the (R) Hearing on the (L) was normal.

4. Nurse scratchpad notes (Case #9064)

Dx: Chronic left SOM
Hx: June 1989: bilat. titanium tubes placed.
May '90: Left tube extruded. June '90 Left SOM, wick placed
July '90: right tube in place, ear dry. Ear gtt in left.
Pt. to be checked in 6 mos. Oct '90 Pt on Augmentin for OM
Jan '91: Pt. on Extendryl and doing Valsalva
Feb '91: Left drum retracted. Hearing loss of 40–60 db in left ear.

Plan: To replace left titanium tube

In (3) and (4), improvements and deteriorations in the patient’s condition are more closely associated, at least by implication, with the presence or absence of tubes.

In addition, the nurses also entered a small additional number of negative observations into the scratchpad: that is, observations that the child had not had previous tube surgery, or that s/he had been scheduled for surgery, but that the surgery had not been carried out. The fact that nurses chose to record these negative observations speak to their lively significance for the nurses, or at least for their perceptions that this history would be relevant for the physician-reviewers who would be following up denied cases with a second level review. Although the criteria for approving surgeries were designed to exclude prior surgery as a feature of decision-making, the presence or absence of prior surgeries retained a real relevance for the participants at this lowest tier of decision-making in utilisation review.

Finally, in a majority of cases (59 per cent), the nurses’ scratchpad entries were followed up with some reviewer-initiated inquiry about the prior surgeries, most commonly at the very beginning of the review process. Thus, the prior surgery was not only considered to be relevant to a case by a nurse-reviewer, it also became consequential as shaping the content of the second level reviews.

During the second level reviews:
Since prior surgery was not one of the criteria on which the reviewer was instructed to evaluate a patient’s case, it might be expected that the nurse-reviewer’s notes documenting such surgery would not enter into the second-level, physician-physician review. However, our findings are consistent with the alternative that prior surgery is an important feature of the shared understanding between the reviewing physician and the attending physician. Prior surgeries appeared as a topic in 41 (or 43 per cent) of our review conversations. In two-thirds of these cases, the prior surgery was introduced at the very beginning of the review, establishing it as a significant (i.e.
mentionable) part of the patient’s clinical history. In some instances, the prior surgery was mentioned by the reviewer as the very first element of the patient’s background, as in (5),

\[
\begin{align*}
\text{Rev} &= \text{Physician reviewing the case for the UR firm} \\
\text{Att} &= \text{Attending physician (normally the surgeon proposing the surgery).}
\end{align*}
\]

5. [9064] [Reviewer shows knowledge of prior surgery]

1. Rev: \text{..... I appreciate your calling us back}
2. HH U: (. I’m with a physician group doing
3. preauthorization for the (NAME)’s insurance
4. company: (. and you may hear a beep as we
5. \rightarrow routinely record. [h Uh I know she’s had u:h PE
6. Att: \quad [’ka:y,
7. Rev: \rightarrow tu:bes befo:re (. some titanium tu:bes an’ then
8. \rightarrow (. one of ’em is ou: t h .hh (. and she was infec-
9. infected back I think in u:h .hh in u:h ( )
10. at least a (wick) was placed. = I guess it- the right
11. tube maybe was infected and then .hh and she’s got
12. a large hearing los:s like forty \text{decibels}. h [.hh U:m
13. Att: \quad [Yeah.
14. Rev: \quad (. is she: uh- th’- th’- question that came
15. up on ’er is whether she’s been: (. treated medically
16. with antibiotics t’ try t’ c- c- eh cu:re the:: curren:t
17. eh serous otitis medi[a on the left with antibiotics.
18. Att: \quad [No no. She doesn’t have- she
19. doesn’t have serous otitu-. hh She has adhesive otitis.
20. Rev: \quad [Oh.

In this instance, the reviewer begins his consideration of the case at hand by reviewing the information that he already knows about the patient. Although the first item on the computer-generated printout from which the patient’s medical history is available is the patient’s age, which is the first decision branch in the criteria’s algorithm, the reviewer begins the history with a description of the patient’s previous tympanostomy tube insertion, which was the first item noted in the nurse’s scratchpad notes (lines 5–8). Indeed the reviewer’s opening remarks follow the nurse’s scratchpad notes in (4) very closely. In this case, as in others, it is virtually certain that the reviewer focused on the nurse’s summary scratchpad notes as narrative guidance for the case, rather than the more complex and less accessible computer-generated paper trail.

In this context, the reviewer’s first mention of criteria-relevant information does not come until line 12 (the 40-decibel hearing loss) and his
question concerning antibiotic treatment, at lines 14–17, displays the problem-
atic aspect of the case vis-a-vis the criteria: the patient had apparently not been treated with antibiotics. Despite this, the reviewer’s first character-
isation of the patient had to do with her prior tubes.

Similarly, in (6), the reviewer mentions the patient’s prior surgery near the 
beginning of his review of her history, second only to her apparent cleft lip 
repair, a circumstance that might be evaluated as extenuating and therefore 
overriding the criteria.

6. [4687] [Reviewer shows knowledge of prior surgery]

1 Rev: I’m doing a preauthorization for the [NAME] 
2 insurance [h company an::’ I appreciate your ti:me, = 
3 Att: Uh huh, 
4 Rev: [=you may hear a bee:p as we: (. ) routinely record 
5 Att: [Sure, no problem, 
6 Rev: .hh[hh I kno:w uh the child has a- (uh) had a cleft 
7 Att: [Sure, 
8 Rev: → repa::ir: i[n February and PE tubes were pla:ced and 
9 Att: → [Uh huh, [Right. 
10 Rev: → now .hhh and now they’re ou:t. .hhh U:h do you know 
11 anything about the past history? Has the kid had a 
12 lotta trouble prior to that with: u:h needing PE tu:bes? 
13 Att: U::m I think this has only been his first se:t? 
14 Rev: Mmmh. 
15 Att: But you kno- uh- you kno:w with ‘(a) ‘ cleft palate an’ all 
16 [that stuff- 
17 Rev: [We:ll, yeah, in fact- uh I’m an otalaryngologist and 
18 cleft pa:late that’s tru:e, = (if) you’re cleft lip I’m not su:re 
19 that it’s the: automatic thi:ng but it-

In this instance, the reviewer begins his review of the case by mentioning the 
facts of the history that he does know: that the patient had had cleft repair 
and prior tubes. As in (5), this was raised as a topic even before the patient’s 
age (which, in this case, later became the most relevant aspect of the 
patient’s history – the child was less than a year old, which the reviewer 
treated as a complicating factor in making his decision). As both (5) and (6) 
show, the reviewers treated the patients’ prior history of tympanostomy tube 
insertion to be not only relevant to the case, but immediately relevant, as 
evidenced by its mention at the start of the review.

This pattern of early establishment of a patient’s history of prior tubes 
held across cases, even when the reviewer did not already know that the 
patient had had such surgery, as in (7) and (8).

7. [1231] [Rev queries prior surgery]

1 Rev: Alright the i:nformation I have is she is about two:: 
2 and a half;
3 Att: Yes,
4 Rev: And pt .hh she’s had uh:: ear infec:ti:ons in the
5 past¿ Ah:: although I don’t have too much information
6 on () how many in the last six months let say .hhh
7 → ah::: I don’t know if she’s had tubes befo:re, ()
8 Actually I don’t have too much i(h)n(h)formation on her
9 maybe you could uh te:ll me a[bout that,
10 Att: [I uh:: I don’t think she has
11 tubes befo:re,
12 Rev: Oka::y,
13 Att: An:đ according to the mo:ther she has repeated
14 ear infections she was treated with amoxicillin and
15 (she ) .hhh and still she is complaining of the
16 ears pulling in the ears and she is not hearing as
17 good as she should¿

8. [6896] [Rev queries prior surgery]
1 Rev: Ye:s. Let me inform <you you’ll hear a beep in th’>
2 ba:ckground, = That’s part of the re:cord:ing.
3 Att: A:lright,
4 Rev: (h)O:ka::y, hh And you were gonna say abou::t uh
5 (Mary), (.).hhh
6 Att: ’ea uh- she uh- (.) we’re gonna put- we were gonna
7 pla:n on puttin’ tu:bes in ’er ears. =
8 Rev: → = Uh hu::h, has she had tubes before?
9 Att: ’et’s see. I th:ink she ha::.
10 Rev: Mmhm,
11 Att: [U::m (0.4) lemme just look here. (0.2) .h Yeah she
12 had ‘em once befo:re (0.2) i:n March of eighty seven.
13 Rev: Mmhm.

In both (7) and (8), the reviewers again raise prior tubes as a relevant topic, although in these instances, that fact remains to be established as the reviewers did not know that aspect of the patients’ histories. The posing of a question to the surgeon regarding prior surgery explicitly raises the surgery as a relevant topic for the review, again, even though it is not relevant to the criteria (and is not considered an extenuating circumstance).

The establishment of prior surgery as a relevant aspect of the patient’s history is, on one hand, perhaps not surprising – for those patients who had had the surgery, it was undeniably part of their medical history. Moreover, it may be that the reviewers treated the fact of prior surgery as an indicator of possible extenuating circumstances that would emerge in the subsequent discussion of the topic. However these references to prior surgery also embody an understanding, shared between the reviewer and the attending physician, that prior surgery is a relevant consideration in evaluating cases for surgery – a medical myth unsupported in the scientific literature.
It is striking that the topic of prior surgery was regularly introduced at the start of the review – the reviewer either mentioned his/her knowledge of it or s/he inquired into it at the beginning of the review of the patient’s history. Thus, from the outset, that aspect of the patient’s past was established. Moreover, prior surgery was regularly mentioned before any of the criteria-relevant aspects of the case, and, especially, before those aspects that worked against approving the case were mentioned. Analysis of the tape recordings of the reviews suggests that this placement of the topic of prior surgery early in the conversation is significant for the resources it seems to provide.

First, it topicalises a matter which, from the perspective of the attending physician, would be grounds for approving the case. By inviting conversation about a factor which is favourable to surgery, it establishes a collegial stance (Boyd 1998) towards the attending physician, and may suggest that the reviewer is not prejudiced against the possibility of surgery. Second, the introduction of the patient’s prior surgery puts in place a possible resource that each participant may later make use of. The previous surgeries may be invoked by the attending physician, whether immediately or distally, to justify the current proposal for surgery. Given the acknowledgement of its significance embodied in the reviewer’s attention to the matter, the case may become more difficult to deny. It may also be a resource for the reviewer, helping to establish the seeds of an account for his/her decision, even before that decision has been reached. This is particularly significant in the context of reviews that involve conflict, and in which the reviewer may ultimately prefer to have a consensual, but inappropriate, basis on which to approve a case and avoid an emotionally draining disagreement with a peer (Boyd 1997).

The explicit orientation of the reviewer and the surgeon to prior surgery as a relevant account for proposing surgery is commonplace in these interactions. In cases where the reviewer did not reference prior surgery, the attending physicians’ narratives described prior surgeries and their sequelae as part of building a case for their decisions to propose surgery. Most commonly (nine of 16 cases), they mentioned previous surgeries as the first component of a response to a request for medical information about the patient. In many of these cases, this information was explicitly introduced as a justification for the current proposal for surgery, as in (9) and (10) below:

9. [8131] [Attending physician immediately cites prior surgery]
   1 Att: Have y- Has the nurses eh- eh- e::h- in your- c- eh-
   2 done- d- dealing with your computer not given you the
   3 information?
   4 Rev: Oh. They did. But you know the:- whatever they give me
   5 is (. ) e- effusion which is only four weeks o [:ld
   6 Att: → [(Do you)
know that this child has had tubes on two previous occasions?

Rev: .h Well, e:h, ((pages turning))

Att: \( \rightarrow \) Do you know that?

Rev: No- Y’know I- I appreciate if you give me your information an’

Att: [The- the child has had te:h tubes on two previous occasions. < Has also undergone a T an’ A for this problem

\( \rightarrow \) The child continues to have effusions (.) now that the tubes have extruded.

In this case the attending physician’s rather hectoring initial response to the reviewer’s request for information about the effusion treats the child’s previous surgical history as self-evidently relevant to the present review, and this is subsequently underscored by his explicit linkage (lines 16–17) between the current effusion and the now extruded tubes. And in (10), the attending physician’s initial reference to previous tubes is connected to the child’s present condition by his comment that the child “promptly” has a recurrence of OME following expulsion of the previous tubes:

10. [7133] [Attending physician immediately cites prior surgery]

Rev: I don’t have any information on him y’know as far as the frequency of otitis media r’ whatever.

Att: He’s a youngster who:: because of recurrent ot- u:h bouts of otitis media: (. ) u:m .h in nineteen eighty seven 

\( \rightarrow \) bilateral myringotomy an- (. ) an’ post ventilating tubes.

(0.2)

Rev: Mmmm.

Att: \( \rightarrow \) The tu:bes sh- u:h expe:led (0.6) someti:me (0.2) middle of nineteen ninety, .hh a:nd he promptly had recurrence of (0.4) effu:sions despite the use of antibiotic the:rapy, 

(0.2) .hh no active infe:ctions but the effusions won’t clea:r.

In contrast to these cases, other initial mentions of previous surgeries in the patient’s history are cited as part of a history of extensive ear problems, though without making an overt connection between the earlier surgeries and the present proposal:

11. [1205] [Attending physician immediately cites prior surgery]

Rev: u:h could you tell me:: u:h (. ) something about this y-
youngster? = I guess you: wanna put in- = th’ = u:h do a (. )
tymp an’ tubes on ’im?

Att: \( \rightarrow \) Okay ’e’s had tu:bes uh twi:ce in: u:m (0.4) nineteen

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In the context of an open-ended request for information about the patient (Boyd 1998), the attending surgeon begins constructing a detailed history of the patient, his relationship with the patient, and his personal, firsthand knowledge of the patient. First, in both instances, is the establishment of prior surgery as part of that rationale. Thus, the attending surgeons display not only that the patients have lengthy and troubled histories of serious ear problems, but that the current situation is not a new one, and so there is ample precedent for the current decision. In a majority of these cases (56 per cent) the physician explicitly connected the previous surgeries to the current proposal[^6]. Whether explicit or tacit, however, these initial mentions act to legitimate the surgeon’s current proposal by displaying a particular historical pattern: each time the patient has had such problems, surgery was the answer; it must, therefore, be the (right) answer now.

While it is evident that a past history of surgery can serve as a starting point from which the attending physician can narrate a history of encounters with the patient, it seems likely that this is at best a secondary motivation for beginning in this way. It is striking that, in cases where the reviewer’s initial question does not address previous surgeries, a majority of attending physicians’ ‘volunteered’ mentions of previous surgery occur as the very first statement in the history. This is so despite the history of other potentially describable contacts with the patient both before the initial surgery, and prior to the present conversation. Taken together with the explicit linkage between previous surgeries and present proposals, the use of these mentions to anchor a justification for subsequent surgery seems inescapable.

It is clear that these initial comments about prior surgeries can be persuasive to reviewers. In the following case, the attending physician’s comments induce the reviewer towards a position (arrowed) that sets up a prospective context for approving the case:

12. [1482]  
1 Rev: I know he’s scheduled on the nineteenth  
2 Rev: fer (. ) tu:bes an’ u:h .hh he had P E tubes inserted  
3 apparently u:h- eh- were you invo:led in that I know  
4 you saw him (. ) as long ago as July:: of ninety  
5 (0.6)  
6 Rev: [Did you put his tubes in before?  
7 Att: [W-  
8 Att: I’m lookin’ here. .hh U:h first of all it’s a she::  
9 Rev: Oh.
Here the attending physician’s account of previous surgeries mobilises the reviewer towards a generalisation about the patient that defines her as in need of PE tubes on a long-term basis, and the case was eventually approved for surgery though it did not satisfy the explicit criteria of the UR firm.

In each of the previous cases, both reviewer and attending surgeon treat the precedent of prior surgery as (part of) an argument in support of its subsequent use. This orientation to precedent is particularly marked when the reviewers, who have no grounds in their mandate for the consideration of prior surgery, announce their evaluations of the cases. In the context of both decisions to deny surgery and to recommend it, the reviewing physicians make reference to the notion that prior surgery can justify subsequent surgery – as in (13)–(16).
he been: seen by anyone else u::hr: (0.2) recently
be[f- = prior t’ this? u:h .h-
Att: [‘(He::’s) ( ) I: do:n’t kno[:w.
Rev: [Yeah.
Att: ( ) uh, ‘’ (too soft to determine
whether the noise is the doctor’s voice or background
noises))
Rev: (0.8) .hh Well the u:h- () and you’re planning t’
do:: uh () just PE tubes not (ad’noidectomy) right?
Att: Right.
Rev: Yeah. .hh .hh Well the- u:hm hh () most charts
don’t really:: end up in the physician review area. =
Th’- () Th’ reason this one di:d () i: u:h an’
I- I understand where you’re comin’ from, you’re-
you’re- () you’re thinking since he had tubes
befo:re that he probably won’t clear u:p, .hhh but
() the question is is there any- is there any
reason why the patient would he har:med <i’ you
tried to treat ‘im with antibiotics an’ wait u:h >
uh little while <t’ see if it> does cle:ar since a
lot of the effu:sions will? .hh

14. [4650] [Reviewer acknowledges the import of prior surgery]

we’re- we’re b- here- we’re basically in a
situation where .hh u:m (0.3) if u:h (0.3) i-
if this were the first set uh tubes there
would be no question. I mean the- the- the:- the
panel ‘as said that u::h .hh u:h you should wait
at least a couple o’ months even if there’s a
significant hearing loss after they’ve had a
course of antibiotics uh t’ see if it’ll clear
up ‘cause most of ’em will. .hh An’ th’- In:- In:
this kinda case where they’ve had them before we
really don’t have it (. ) well do:ocumented that it-
that it wouldn’t clear up based on prior treatment. =
He’s only been on the antibiotics for: a fairly
short period o’ ti:me,

In both of these instances, the reviewer addresses the prior surgery as a possible indicator for, or justification of, the current proposal for surgery, even as he is on the way to denying the case. In so doing, the reviewer both acknowledges the legitimacy of the attending surgeon’s proposal for surgery, and, by acknowledging it, does his best to mitigate the negative decision. Here, while the acknowledgement of the relevance of prior surgery is a vehicle for mitigating a decision, using it in this way renews the common
culture of this medical specialty, and helps to perpetuate the perceived relevance of prior surgery.

This is even more pronounced in cases where the reviewers accepted the precedent as a legitimate override of the criteria. In the next two instances, the reviewers invoked prior surgery as a primary basis for overturning the first-level review and recommending the case for surgery, even though the formal criteria were not satisfied.

15. [1302] [Reviewer uses prior tubes as basis for overturning decision]
1 Rev: Yeah th- th- th’ problem that comes up in a case like this uh
2 → (.) but uh which, when I heard she had previous tubes I was
3 → gonna go an’ approve it, is that since she’s only been on
4 antibiotics for one month we really don’t know what’d happen
5 in the next month. Uh when she came back in.
6 → But with this much hearing loss and previous tubes uh uh eh I’ll
7 → go ahead an’ approve it.

16. [6190] [Reviewer uses prior tubes as basis for overturning decision]
1 Rev: Well no I’m not saying what they need or not. I’m just
2 → saying that uh hhh I’m gonna go ahead and recommend it
3 → because uh th fact that u:::h with prior tubes it appeared that he
4 → did well.

In these final instances, prior surgery is explicitly named as the basis for the reviewer’s decision to recommend the case for surgery despite the fact that the criteria were not met. Allowed as a sufficient precedent to justify surgery, the myth of prior surgery thoroughly undermines the rational process of the review, while simultaneously being perpetuated through its use.

The summary justifications for approving cases for surgery:
Finally, despite the fact that the UR firm’s explicit criteria do not recommend using a history of prior surgery as a basis for their decision making, the reviewing physicians made reference to such surgeries no less than 33 times in their handwritten reports summarising the case for surgery. These entries varied in the extent to which the previous surgeries were explicitly used to justify subsequent surgeries. Thus, in some cases, previous surgeries were simply mentioned as part of a decision-making ‘package’ of considerations supportive of a decision to approve the case:

17. [Reviewer summary: Case #8658]
9 year old male w/ eustachian tube insufficiency. Hx of recurrent OM since 1987.
→ Had 5 episodes of SOM until tube insertion late ’87. Tubes came out
last year and had two episodes AOM in ’89 and now has persistent effusion.  
2.5 mos on ABX directed at effusion. Hearing loss 35 db. Discussed cases w/ Dr. L. – approved med. nec.

18. [Reviewer summary: Case #6190]  
→ 6 year old child w/last set tubes 6/90 and did well. Seen by Dr. [Name] 5/31/91 w/ SOM and hearing loss. Rx x 1 mo – no improvement on 6/25 visit.  
→ In view of recurrent SOM after tubes out, will rec tubes at this time.

Noteworthy in this context is the fact that previous surgeries are mentioned even when the case otherwise merits approval in terms of the UR firm’s criteria. For example, Down’s Syndrome is an extenuating circumstance mandating surgery. In the following summary, the condition is cited but the previous surgery is also noted:

19. [Reviewer summary: Case #8988]  
→ 7 year old male with Downs syndrome, persistent middle ear effusion, speech problems and hearing loss (20–30db). Effusion now present x 6 weeks.  
→ Patient last had tubes in 1986.

Similarly, in (20), the child’s prior history of otitic meningitis would be an extenuating circumstance for surgery. Nonetheless, the reviewer adds the references to previous surgeries to bolster the case:

20. [Reviewer summary: Case #1149]  
→ 3 year old child w/ hx otitic meningitis at age 1.  
→ Had tubes placed immediately after recovery. Had second set of  
→ tubes placed 11/89 which are still in but are now occluded w/ crust.  
→ Child did well w/ tubes but now has effusion and had otitis 2 weeks ago.  
→ In view of recurring effusion after blockage of tubes and previous severe complication of otitis media, will recommend tubes as medically necessary.

In other cases, however, previous surgeries are explicitly used to justify the present decision favouring surgery, as in (21):

21. [Reviewer summary: Case #1205]  
→ 4 year old child with recurrent episodes of SOM. Previous tubes.  
Has seen ped and noted to have fluid level again. Child is allergic as well. ( ) Rx for allergy by peds.  
→ OK for surgery because of repeated tubes and recurrent fluid.

Through these entries, the reviewers imported the informal ENT culture which they oriented to in their phone calls directly into the official work of
the UR firm whose criteria were designed to exclude such considerations from the decision-making process. Prior surgery thus becomes an account for a decision that subverts the very criteria the reviewers were mandated to implement.

As we have suggested, the documentation and discussion of previous surgeries on these patients has a significant impact on the reviewers’ decisions. As Table 4 shows there is a strong association between previous surgeries and approvals for current surgeries.

Table 4: Previous surgeries and outcome of the current review

<table>
<thead>
<tr>
<th>Previous surgery</th>
<th>Deny</th>
<th>Approve</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>23 (43%)</td>
<td>31 (57%)</td>
<td>54 (100%)</td>
</tr>
<tr>
<td>One</td>
<td>7 (21%)</td>
<td>26 (79%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>More than one</td>
<td>0 (0%)</td>
<td>9 (100%)</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>30 (31%)</td>
<td>66 (69%)</td>
<td>96 (100%)</td>
</tr>
</tbody>
</table>

Pearson chi2(2) = 8.8722  Pr = 0.012

All the inappropriate decisions that were made by the reviewers involved approvals, rather than denials, of cases. And, as Table 5 shows, there is a strong association between previous surgeries and decisions to approve new surgeries that are not justified by the UR firm’s criteria.

Table 5: Previous surgeries and appropriateness of reviewer decision making

<table>
<thead>
<tr>
<th>Previous surgery</th>
<th>Appropriate</th>
<th>Inappropriate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>31 (57%)</td>
<td>23 (43%)</td>
<td>54 (100%)</td>
</tr>
<tr>
<td>One</td>
<td>17 (52%)</td>
<td>16 (48%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>More than one</td>
<td>1 (11%)</td>
<td>8 (89%)</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>49 (51%)</td>
<td>47 (49%)</td>
<td>96 (100%)</td>
</tr>
</tbody>
</table>

Pearson chi2(2) = 6.6211  Pr = 0.036

Indeed logistic regression of a range of factors has shown that previous surgeries are the second most significant factor (after patient sex) associated with inappropriate approvals (Kleinman et al. 1997: 500, Table 3).
Discussion

This paper has shown how clinical experience and precedent are treated as legitimate bases for clinical decision making, even in the context of the rationalised process of utilisation review. In this context, where explicit criteria are supposed to be upheld, this use of precedent serves effectively to limit the potential impact of the criteria on clinical practice. As Becker et al. noted, experience here is ‘used to rule out some of the procedures which have been scientifically established’. Here, the criteria’s preference for antibiotic therapy or watchful waiting was frequently ignored in favour of surgery. A history of prior surgery was treated as sufficient to justify current surgery, even though otitis media frequently moderates with age, and evidence to justify the effectiveness of the prior surgery was often scarce. Children with a history of prior tympanostomy surgery were almost 31 times more likely to have their current surgery approved by the reviewers than those with no such history, controlling for a number of important variables (Table 2). In other words ‘once a candidate for tympanostomy tubes, always a candidate for tympanostomy tubes’.

Belief in the relevance of prior surgery as grounds for new surgery is widespread in the culture of otolaryngology. As we have documented, communication about previous tympanostomy tube surgeries emerges at every level of the review process and the information that is generated is apt to recur across levels. Thus, in 28 of the 32 (87.5 per cent) cases in which the nurse documented previous surgeries in the scratchpad, there is some further mention or discussion of that in the review conversation. Of the 41 total cases in which references to previous surgeries emerged, the reviewer noted the history of prior surgery in his notes justifying the decision in 33 (80 per cent) of them. The presence of other clinical indications that would represent extenuating circumstances, and which would have been enough to justify approval of the surgery, did not deter the reviewers from noting the prior history of tubes.

There is no evidence in any of our data to suggest that the reviewers or the attending physicians are engaged in any kind of instrumental subversion of the review process. On the contrary, the telephone conversations indicate that the attending physicians sincerely believed that previous surgeries clearly justified future surgery. These beliefs are evidently shared by many of the nurse-reviewers and some of the physician-reviewers as well. The physician-reviewers included prior tympanostomy as part of their ‘official’ justification to the UR firm, demonstrating a belief in the relevance of this precedent. Thus, the subversion of the UR firm’s criteria is subtle and occult. Drawing on a broadly shared, cultural understanding of the role of surgery in treating recurrent illness, and found at all levels of the review process, prior surgery is treated by all parties as a critical and consequential finding that is relevant to the decision at hand. Its relevance is treated by all
parties as immediate, and its status as an account is treated as unproblematic. In many ways, this is a circular self-validating belief functioning at a near-presuppositional level in many of these review conversations (Pollner 1987). It is unproblematically used to justify approving cases for surgery, and special pleading is involved in defeating its relevance for surgery.

From the perspective of the reviewers, who are peers of the reviewed physicians and stand in a potentially collegial relationship to them, rejection of the relevance of prior surgery is difficult to manage and is only attempted when the reviewers tried to justify denying the case for surgery. Not only is the relevance of prior surgery for future decisions shared within the ENT culture, reference to it by the reviewers is a means both of building a collegial relationship with the attending physicians, and positioning themselves as sympathetic to the attending physicians’ proposals for the case (Boyd 1998). Moreover, denials of these cases were often conflictual and emotionally stressful for the reviewers (Boyd 1997). The history of prior surgery provided a consensually validated rationale for approving the case in the context of the review process, even in the case of discord with the criteria. Thus the invocation of prior surgery both exerted pressure on the reviewers to approve the case, while making it easier for them to do so.

Conclusion

This is a study of the ways in which the informal culture of medical practice, with its essentially autonomous and particularistic ways of making medical decisions, is introduced into a system of utilisation review that was designed to embody the highest standards of scientific rationality. Through the interactional administration of utilisation review, this informal culture leaks into the putatively technocratic system of evidence-based medicine, inserting into both the process and its outcomes a kind of collegial mythology that, from the point of view of scientific medicine, is based on half-truths or no truth at all.

Although this is an examination of some of the practices by which physicians perpetuate a particular medical myth, this study also reveals the complexities, as well as some of the difficulties, involved in efforts to ration health care. Hunter (1997) and Mechanic (1995), among others, have suggested that forms of explicit rationing, such as the utilisation review process examined here, are especially vulnerable to duplicity or efforts to “game the system” as physicians (and other professionals) attempt to circumvent explicit criteria. While that may be the case, this study shows that the implementation of explicit criteria may be highly vulnerable to more subtle means of subversion based on shared and quasi-presuppositional beliefs within the medical profession. As long as these beliefs remain entrenched within the culture of medicine, the implementation of efforts to ration and rationalise health care will remain susceptible to such occult subversion.
This paper has provided evidence of the subversion of scientifically and bureaucratically rational decision making by the members of a medical specialty. However, these data were gathered at the beginning of the UR firm’s development of prospective utilisation review. The reviewers were often faced with attending physicians who were deeply unhappy with the very idea of utilisation review, and especially its prospective use. As one otolaryngologist lamented, ‘I really appreciate medicine being played by someone three thousand miles away from the patient, [who has] never seen the patient and then decides what is good for the patient’. Others, whose proposals for surgery were denied, lambasted the review process: ‘What you’re doing actually has nothing to do with medical care. It has absolutely nothing to do with quality of care. It has to do with saving a buck’. It is in this context, of course, that the reviewers came to overturn about two-thirds of the first-level reviews and approved the cases for surgery, most of them inappropriately.

The relative inefficiency of the review process as a means of rationing care was quite visible to the UR firm. Nonetheless, it can be suggested that such an inefficient and dysfunctional review process has long-term value from the perspective of those who would ration care. These data represent the introduction to attending physicians of a process to hold their medical decisions accountable in terms of explicit criteria. While both the attending physicians and the reviewing physicians collaborated in subverting these criteria, it is possible that another, and deeper, process of occult subversion was at work. The object of this subversion is the very notion of physician autonomy in medical decision making, and the incipient replacement of the collegial regulation of medical practice with that of a bureaucratic process. Indeed the rationing of health care in the name of quality of health care must ultimately depend on co-opting medical professionals to relinquish their autonomy. The use of physician-reviewers, who share mythical and cultural beliefs with the attending physician, to initiate this process may actually have been effective in contributing to this co-option. In this way, the dysfunctional aspects of the review process described here may have made a contribution to the changing pattern of practices in medical decision making in managed care.

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assistance in creating the original study design and the sampling scheme. Dr. Robert H. Brook provided important conceptual and practical insights.

Notes

1. At the time of the decision, the surgeons were given an 800-number to call to initiate appeal proceedings. The physician-reviewer was not involved in the appeal decision.

2. Potential complications of tubes include perforation of the tympanic membrane, scarring and permanent low-grade hearing loss [Kleinman 1997], as well as the general threat from anesthesia.

3. A study by Kleinman et al. (1994) of some 4000 tympanostomy surgeries found that 41 per cent were appropriate, 36 per cent were equivocal and 23 per cent were inappropriate in terms of criteria described below.

4. The Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Healthcare Policy and Research, AHCPR) has also issued national guidelines for the appropriate use of tympanostomy tubes for the management of otitis media. Kleinman (1997) demonstrates that the AHCPR guidelines are much more restrictive than the UR firm’s criteria, both in general and when applied to this population.

5. The official extenuating circumstance involves cleft palate, not lip. This issue later became the focus of discussion in the review.

6. In a total of seven out of 16 cases in which attending physicians initiated mentions of prior tubes they associated previous surgeries with positive effects (the patient ‘did well’), or associated current difficulties with loss of benefits from previous tubes which had ‘become extruded’ or ‘blocked’. Such associations were more common when attending-initiated mentions of previous surgeries occurred at the beginning of the review process, rather than as a more ‘en passant’ or embedded mention as part of the child’s medical history. Assertions of medical benefits associated with prior surgeries occurred in less than 10 per cent of the cases in which reviewers questioned attending physicians about prior surgeries.

7. The reactions to these non-legitimate reviewer justifications on the part of the UR firm and the third party payers it represents are not known. The UR firm had records of each reviewer’s approval rates and may, on occasion, have examined individual reviewer records. However the volume of reviews likely precluded detailed analysis of reviewer justifications.

References


